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ABSTRACT

Five final reports on the Nursing Curriculum Project of the Southern Regional Education Board are presented. The reports include (1) RN (Registered Nursing) Education: The Basic Issues; (2) Types of RN Programs; (3) Planning and Operating an RN Program; (4) Acclimating the Novice Nurse: Whose Responsibility? and (5) Statewide Planning for Nursing. A synopsis of SREB's Nursing Curriculum Project for 1972-1981 is provided, along with an outline on the characteristics and levels of nursing practice for primary and secondary care. Specific topics include the issues surrounding career mobility and educational opportunities for RNs and the current and future need for baccalaureate nurses. Six options for RN education are discussed: advanced standing in generic programs for baccalaureate students, "RN only" programs, outreach or satellite programs, competency-based education, independent study, and directly articulated programs. Effective planning and the operation of an RN program are covered, with attention to funding, the curriculum, challenge examinations, teaching strategies, and faculty. Additional topics include: the use of a modular, individualized learning system to help new graduates on the job, and results of demonstration projects in statewide planning for nursing education. (SW)

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A series of final reports on the SREB Nursing Curriculum Project

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SOUTHERN REGIONAL EDUCATION BOARD

Southern Regional Education Board

PATHWAYS TO PRACTICE

Number 1 in a series of final reports on the Nursing Curriculum Project

RN Programs: The Right of Passage

RN Education: The Basic Issues

Can We Afford More Education for RNs?

During the 1980s, increasing pressure will be placed on policymakers to decide if scarce educational resources should be invested in special programs for licensed nurses who seek higher academic credentials. Until now, legislatures, commissions of higher education, and colleges and universities have vacillated on the question of such RN programs. Action has ranged all the way from mandating class spaces or special programs for registered nurses to discouraging their enrollment because their graduation will not add to the RN pool.

Usually, RN students are diploma or associate degree (AD) graduates who are earning baccalaureate degrees, but they may be licensed nurses with baccalaureate degrees in other disciplines, such as education or psychology, who are working toward the master's degree in nursing. Special "tracks" for RNs within ongoing baccalaureate programs have a long history of success; despite that fact, spaces for RN students in these generic* classes are often limited, not only because resources are short but also, some say, because interest in educating these nurses remains low.

The fundamental questions are complex and need to be carefully examined before good decisions about RN education can be made. First, as Americans, we believe that opportunity for educational mobility should be available to all persons who have talent, the price of tuition, and the willingness to work toward higher personal and professional goals. However, health care education is expensive and therefore enrollments are limited. Although class space is usually available in associate degree programs, it has been scarce at the baccalaureate and graduate levels, but this is beginning to change as baccalaureate programs continue to see slight declines in enrollment. Nonetheless, the current demand in many areas of the country for RN class space is greater than the supply.

Proponents of greater educational opportunity for RNs cite a number of reasons for their stand. First is the need for more highly skilled nurses in hospitals, where the acuteness of illness has risen dramatically. On the average, patients are much older and sicker than they were only 10 years ago. Second, current trends indicate that more nurses who are prepared for the various forms of community health practice will be needed. For example, as alternatives to hospitalization become more common, we will need to prepare more nurses to give nursing services in primary care settings like the home, the clinic, and other ambulatory care settings; at the undergraduate level, only the baccalaureate offers the appropriate coursework and clinical preparation. As this moderate shift away from hospital practice continues, our need for RNs with more education will rise. Third, sheer economic pressure makes programs for part-time RN students highly attractive, as the RN student can continue serving patients while studying for the baccalaureate degree. Finally, and perhaps most important in the long run, is the need to increase the number of nurses with a commitment to their careers rather than simply a commitment to the current job. Increasing the number of nurses with four or more years of college improves the quality of care available to patients, for, according to the federal Women's Bureau, the more education a woman has, the greater likelihood she will seek paid employment. Among women with four or more years of college, about three out of five were in the labor force in 1978. Nursing data confirm the fact that nurses do not differ from other women in this respect. Despite these arguments, debate over the practical wisdom of increasing the educational resources allocated to RN students continues.

Seven projects under the auspices of the Southern Regional Education Board's Nursing Curriculum Project (NCP) addressed these and related issues in RN education. The University of Maryland and the University of South Florida undertook outreach programs at sites removed from their main campuses. The University of North Carolina at Greensboro, Northwestern State University of Louisiana, Prairie View A&M University at Houston, and the Medical University of South Carolina all tested various innovative approaches to RN education. George Mason University provided a faculty

*Generic: An upper division baccalaureate nursing major built upon a base of liberal arts and sciences.

development program for RN teachers in the region. (Detailed descriptions of each of these seven projects will be available in a separate publication, *Reports of Seven Demonstration Projects.*)

The purpose of this publication is to focus attention on the issues surrounding career mobility which are raised by the question of RN education. The NCP's original recommendations were broad, *a priori* statements that needed further point and focus; the NCP's seven demonstration projects were designed to provide just that, in the form of concrete tests and models for future developers of RN programs. This summary of the basic issues is based on our experience with those tests and models.

The issues are quite clear. Is there a right of passage for nursing graduates from associate degree and diploma programs to upper division ones, and, if so, what can be done to facilitate student access to these educational opportunities? Should there be multiple curricula available to RN students or one (rather) universal plan for educating these part-time working nurses? How can nursing programs be better structured to facilitate the learning of the adult student? Who is to bear the costs and the responsibilities for further educating these already licensed nurses?

The demonstration projects conducted under NCP present models for granting advanced standing in generic nursing programs, curricular adaptation to accommodate the registered nurse student, atypical time and place options for study, and ways of working with the adult learner to preserve motivation to learn and enhance self respect.

The RN's Right of Passage: Career Mobility

Providing career mobility for RNs through education has always been fraught with controversy. While some educators feel that RN tracks and programs are unnecessary, others feel that they are the future vehicle for all baccalaureate nursing education. Some favor a concentrated effort for the next 10 years and then a permanent closing of baccalaureate programs to RN applicants. Still others propose direct articulation of baccalaureate programs with community college curricula. Some favor awarding advanced standing to RNs in existing generic programs only. The diversity of options has resulted in the development of several types of programs to provide opportunity for registered nurses to obtain the baccalaureate degree.

Controversy about upward mobility for graduates of associate degree (AD) programs originates partly with the assumptions developed in a curricular project begun in 1952 by Montag. Associate degree education—in that project and several others—was thought to be technical and terminal. It was believed that nurses should be prepared for at least two different roles having different nursing functions. The two roles necessitated two different educational programs—associate degree and baccalaureate—offering two different kinds of education.

Further, Montag believed that AD and baccalaureate programs could not and should not be articulated, directly or otherwise. The purposes, curricular content, and teaching methods of the two programs were so different, she believed, that it was not possible to apply a ladder concept of curriculum development to them. In regard to upward mobility, Montag now says that "the early programs were content with being what they were intended to be—complete within themselves, possessing an integrity of their own." In the 1980s she suggests that if too much attention is paid to articulation with the baccalaureate program, both programs will suffer.

> So much emphasis on mobility leads me to suspect a less than complete confidence in, or acceptance of, the technical program and ultimately in the differentiation of functions. If this is so, then we have returned to the idea that "a nurse is a nurse is a nurse." When AD programs were still in their pilot stage, we stated that we believed this would be the only formal education for most of the students, but that no barriers would or should stand in the way of those who sought to change their career goals. I see no reason today to change that belief (Montag, 1980, p. 249).

Since 1952, Montag's conclusions have been supported by many nurse educators; indeed, they are reflected in the 1965 American Nurses' Association (ANA) position paper on nursing practice and education, calling for the preparation of two kinds of nurses—technical and professional. The two kinds of nurses would practice in different nursing roles. The professional nurse would earn the baccalaureate degree, building upon the broad base of the liberal arts, and the technical nurse would earn a lower division nursing degree, preparing for more circumscribed functions.

Like the nurse with the associate degree, the graduate of a hospital-based diploma program has been designated a "technical nurse." Hospital programs of nursing education were also intended as complete entities, but they are not a part of the mainstream of higher education. Nevertheless, in spite of a substantial decline in the number of diploma programs since the advent of the associate degree in nursing, the majority of registered nurses now practicing are diploma graduates. Many of the people in this large pool of nurses want the baccalaureate degree, and they feel that their career mobility is blocked without it. In the last decade or so, diploma graduates in many locations have been counseled into imprudent choices when the only bachelor's curricula available were in fields other than nursing. It is doubtful that earning a bachelor's degree in, say, business administration can improve the nurse's ability to provide direct patient care; debate over this issue has added to the pressure on nursing education to make baccalaureate curricula more accessible to registered nurses.

The controversy about career ladder programs has continued unabated. Currently practicing nurses who do not hold an advanced degree have demanded easier access to advanced education, voicing those demands through their professional organizations. Of the 1.4 million nurses holding a current license to practice, 67 percent hold a diploma from a hospital school; 17.5 percent hold a baccalaureate degree; 11 percent, an associate degree; and 4 percent, a graduate degree (Moses and Roth, 1979). This educational record does not even come close to the standard set by the Surgeon General's Report issued in 1963 or the standards developed by the Western

Interstate Commission on Higher Education (WICHE) in the Seventies. Because of these facts, delegates to the 1978 ANA convention passed a resolution calling on nurses to be active in their support of educational mobility programs of high quality that employ flexible approaches to the assistance of nurses who are seeking advanced degrees.

These nurses have also lobbied state legislatures for laws to make various forms of educational mobility for nurses mandatory. Their first success came in California in the 1970s, when the state legislature mandated the opportunity for students at the end of their junior year in the generic baccalaureate nursing program to take the RN licensure examinations, thus making it possible for associate degree graduates to "test out" of the junior year.

This law was followed shortly by one in Arkansas mandating options for educational mobility. And further, as a result of their own lobbying efforts, RN students have obtained a number of programs that were developed to serve the particular needs of part-time working students who live at a distance from the main campus of an institution.

In 1978, "entry into practice" resolutions were introduced by the Commission on Nursing Education to the delegates at the ANA Convention. The delegates ratified the concept of two levels of practice and again chose the baccalaureate degree as minimum preparation for entering professional practice. However, this time there was something new; these resolutions were tied to the licensure laws. The convention recommended that, by 1985, the initial professional license be awarded solely to baccalaureate graduates. But according to Styles and Wilson (1979), the rejection of the word *level* when referring to "professional" or "technical" and the substitution of the word *category*, were the most revealing aspects of the deliberations, for they exposed the continuation of the conflict. The authors observed that "among the egalitarian 'nurse is a nurse' forces, category is preferred to level" because to them it implies the absence of hierarchy—one category is not necessarily subordinate to another. However, they went on to note that separatists also preferred "category" because to them it suggests that "there is no passage between what may be called, for lack of more precise terms at the moment, the non-professional and professional categories; that is, these are not different levels, but different universes" (Styles and Wilson, 1979, p. 44).

Most educators have abandoned the original Montag concept of the associate degree as terminal, if recent nursing literature and practice are any indication. Consequently, educational mobility is much on the minds of both educators and actively practicing nurses. When the delegates to the 1978 ANA convention adopted the resolution calling for more accessible career mobility programs using flexible instructional approaches, their assumptions were (1) that the education of nurses should take place in colleges and universities, (2) that the overwhelming majority of nurses lack baccalaureate preparation, (3) that nurses' employment potential is based on their credentials, and (4) that large numbers of nurses face limited educational opportunities (Styles and Wilson, 1979, p. 44).

The ANA's passage of this resolution has focused attention on the shortage of opportunities available to RNs who wish to continue their formal education while practicing and earning a living. Though it is true that programs have been devised with the kind of flexibility working RNs require, it is also true that the number available in any given location is usually limited or even nonexistent.

The Need for Baccalaureate Nurses

Just how many levels, kinds, or categories of nurses are needed for the optimal delivery of nursing services is hotly debated. The question has divided the nursing, education, and health care communities for the last 50 years. Since the 1930s, at least two distinct categories of nurses have emerged (technical and professional), but even in the face of that fact, many nurses have continued to be more egalitarian than was ever necessary or desirable. As Smoyak said, "Nurses seem to have an almost compelling, driving need to deny differentiation. We're all the same. No one is different. No matter how we are prepared, we all take the same licensing examination and write the same initials after our names. . . . This deification of sameness has almost destroyed nursing. . . ." (cited in Montag, 1980, p. 250).

Moreover, the nursing community has conveyed this attitude toward policymakers in education, with the consequence that increases in the numbers of baccalaureate programs, including those designed for educational mobility, have been hard to sell. Administrators quite reasonably ask, "Who needs more baccalaureate graduates when nurses are all alike?"

To meet the need for a clear and rational basis for distinguishing one kind of nurse from another, the NCP, in 1974, defined the differences between the beginning generalist programs—AD and baccalaureate—in terms of the competencies of their graduates and the general body of nursing knowledge that should be taught in each program. Briefly summarized, the NCP defined the two types of programs as follows:

- The *AD program* prepares the graduate to function as first-level staff nurse in *secondary care*—i.e, as a generalist attending to illnesses that are common, recurrent, and relatively predictable.
- The *baccalaureate program* also prepares for *secondary care*, but in addition, for beginning positions in *primary care*—i.e., health monitoring and disease prevention, usually in non-hospital settings—and should also provide the graduate with an optional *area of concentration*.

A descriptive outline of the characteristics of practice for these levels and roles is shown on pages 4 and 5.

Without addressing the licensing question, the NCP also identified many roles and levels of practice required in the nursing field (see figure). The focal question was, Is there one role having both professional and technical parts, or are there different roles so that each practitioner is prepared for a different scope or breadth of practice?

Because so much of the earlier work of the NCP was devoted to defining multiple roles, five former project participants were asked in 1977 to review the original work and make suggestions for change, if needed. They

made several small adjustments in the original scheme, which have been included in the figure. Together, the definitions in this scheme provide a skeletal structure on which to build a system for career mobility.

Characteristics of practice for each of the identified roles were developed and reflect pathways for educational mobility, each higher educational program building on the lower one. Knowledge and abilities beyond those held by the graduates of the AD programs are required of the baccalaureate nurse, and these should be the focus of RN tracks and programs.

In addition to the skills and knowledges necessary to practice secondary care—the sole focus of the AD or diploma program and the area of clinical practice in which the RN student typically is not only already educated but also has had experience—the baccalaureate graduate should be skilled and knowledgeable about primary care and an elected area of specialty practice in which there have been concentrated experiences during the baccalaureate program.

The Future Need for Baccalaureate RNs

Just how many nurses with primary care abilities are going to be needed cannot be known with certainty, but most health care economists and many practitioners would agree that every available means should be employed to strengthen and enlarge the role and acceptance of primary care in health services.

This difficult goal cannot be achieved through changes in nursing education alone, of course. Not only must we expand primary care courses in both graduate and baccalaureate nursing education, but we must also establish clear health planning priorities, promote the expanded use of Health Manpower Organizations and family health centers, and encourage the development of financing mechanisms that will pay for primary care services.

Primary care designates the patient's life-long or basic point of contact with the health care system. At the very least, this includes the person's first contact with the system in any given episode of illness. It also includes the individual's long-term enrollment in and interface with the system: the continuous monitoring of one's state of health.

Adequate primary care services, where available, have already proven their ability to make a dent in the forces that drive health care services further into dependence on costly hospitalization and high-technology care, even for the terminally ill, and to help assure a delivery system that is balanced and comprehensive. As two observers put it, "the key to the proper use of hospital beds is not more and more regulation. . . but a strong and organized system of primary care clearly coordinated into a wide range of related services" (Somers and Somers, 1977, p. 436). Specifically, these will include the full range of primary care services, long-term institutional and home care for the aged and the chronically ill, and essential

Characteristics and Levels of Nursing

Entry Level: Characteristics of Practice in Secondary Care

Practice:

- is directed toward clients who are experiencing acute or chronic illnesses that are common and well defined and who have been identified as being ill or in need of diagnostic evaluation.
- consists of processes that are standardized, in common use, and directed toward alleviating both biophysical and psychosocial health problems, the outcomes of which are usually predictable.
- includes making nursing judgments on scientific knowledge that is specific and factual.
- is concerned with individuals but is given within the context of the family and the community.
- is under the leadership of a more experienced staff worker, a generalist clinician, or a clinical specialist.

Entry Level Competencies: Generalist Clinician

In addition to secondary care competence at the beginning level, the generalist clinician posesses beginning competencies in primary care (described below), plus other competencies in an area of concentrated study.

Primary Care: Level I

Practice:

- is directed toward providing services for health maintenance and health promotion—
  - to interpret health for individuals and groups within the context of their sociocultural milieu,
  - to develop goals with clients that are related to the normal stresses of daily living,
  - to treat or monitor clients having selected minor pathological conditions.
- consists of processes that enable the nurse to—
  - assess the health of normal individuals or clients with minor pathology,
  - screen and either treat or refer clients who are in need of further treatment or attention,
  - manage the long-term care of clients with chronic health problems,
  - teach the basic health promotion concepts.
- includes making independent decisions about health maintenance.
- is concerned with establishing a data base that is interpreted clinically.
- is based on knowledge that is developing and evolving; is future-oriented; contains moderate level of abstraction; involves critical thinking.
- includes the application of clinical research to decision-making.
- occurs in a setting having consultative and referral services readily available.

preventive services at all ages. Already, specific packages of preventive services, including appropriate screening, counseling, and therapy, have been assimilated into current financing and organizational patterns. According to the NCP's scheme of nursing roles, the nurse with the baccalaureate degree will have an important role to play in these coming developments.

The work of nurses in primary care has grown appreciably. In 1972, there were 40,567 nurses employed in public health and community practice; but in 1977, there were 77,139 employed primary care nurses, representing a 53 percent increase and accounting for the largest area of growth among all categories of nurses during those years. The number of nurses practicing in nursing homes and extended care facilities also increased—42 percent from 1972 to 1977—representing another sizable area of growth (Moses and Roth,1979).

Requirements for nurses in primary care can be expected to continue to rise for several reasons. As hospital admissions become increasingly limited to the most acutely ill, the number of less acutely sick persons needing out-patient and home care has increased. The number and the complexity of care problems that they present to nursing has also risen. De-institutionalization of long-term chronically ill persons without adequate follow-up has also expanded the need for nursing services. Concomitant with these factors is a developing interest among Americans to keep their dying family members at home or in hospices. To add to the increasing demand for primary care, the growing elderly population is using an increasingly disproportionate share of community and nursing services. In addition, alternative care patterns, such as home births, birthing centers, and self-care, to name but a few, are sought by many citizens.

Hospital nursing practice has also become more demanding during the past decade, because hospital patients are sicker and older. Several kinds of elective surgery now are being treated on an out-patient basis. Patients who would formerly have been admitted for diagnostic tests and routine work-ups are now generally required to get these services on an out-patient basis, in an effort to control the costs of hospitalization.

The lid to this growth may eventually be determined by the federal government deciding on the type and level of insurance support to be provided for or required of Americans. The basic options are either to spend money on health services directed toward prevention and maintenance, which could significantly reduce the incidence of illness at a low per person cost, or to continue to underwrite high cost treatment.

Such considerations as these were taken into account in the WICHE study, one of four independent projects commissioned in the late Seventies by the United States Public Health Service Division of Nursing to determine and project present and future needs for nursing manpower. The WICHE study encompassed a consideration

Practice: Primary and Secondary Care

Secondary or Tertiary Care: Level II*

Practice:
- is directed toward clients experiencing acute illness episodes and presenting problems that are uncommon, moderately complex, and usually immediate.
- is directed toward clients who have been identified as being acutely or critically ill.
- consists of the use and development of innovative and less standardized processes that are geared and adapted to the specific needs of the clients; outcomes are less predictable and require monitoring and a broader knowledge base from which to draw inferences.

Primary Care: Level II*

Practice:
- is directed toward clients from more diversified populations requiring health maintenance and health promotion services.
- consists of processes that—
  - set the appropriate priorities in meeting needs of population being served,
  - coordinate the total services needed by individuals and groups,
  - use the appropriate consultation and supervision,
  - include independent primary assessment, such as history, physical, emotional, and developmental diagnostic work-up.
- consists of developing innovative and less standardized processes geared and adapted to meet the needs of individuals, groups, and communities where outcomes are less predictable and require additional monitoring over a longer period of time.
- includes knowing the nature of the community, the service available, and the means of access to those services.

Special Interest Areas: Common Competencies

Practice:
- is based on a broad range of principles and concepts drawn from a variety of basic and applied natural and behavioral sciences.
- includes making nursing judgments based on the analysis of numerous variables and the prediction of future clinical events.
- includes the application of clinical research to decision-making.
- is based on clinical decisions made from the integration of knowledge of biophysical and psychosocial cues with the recognition of their implications.
- is directed toward providing leadership in the management of care for groups of clients as well as for those personnel assigned to provide that care.
- is directed toward developing collaborative relationships with other health workers providing other kinds of care and services to clients.
- is more self-directive, but the nurse recognizes the need to seek additional information and consultation from peers or higher-level practitioners.

**Alternative areas of concentration.*

of the differing nursing roles and levels of practice needed in the present system of health care and projected future needs. The roles and levels of practice used were similar to those proposed by the Nursing Curriculum Project in 1975 (see figure).

Using WICHE's conservative criteria, it was determined that there is currently a surplus of some 332,000 diploma and associate degree nurses and a deficit of 506,000 baccalaureate nurses in the United States. Using the most liberal criteria determined by WICHE, the surplus of associate and diploma nurses would be reduced to 202,000, but the deficit of baccalaureate nurses would climb to 834,000. A study by Grace estimates that, if these goals are to be met, 850 to 1,000 new baccalaureate programs—over and above the existing 350—will be required (Lysaught, 1981, pp. 138, 104).

These goals, of course, reflect need as defined by one or more interdisciplinary groups of health professionals, rather than actual demand in terms of budgeted positions. However, they also reflect the judgment of experienced health care professionals who see the way roles are evolving and the coming changes in health care needs. Research has not been very helpful to those attempting to project needs for different categories of nurses. Studies have chiefly measured performance of tasks and have not addressed possible differences in the ability to make and apply clinical judgments.

Projections like these are overwhelming and perhaps will be dismissed by some as being visionary. However, even if we were to eliminate consideration of new roles and confine our thinking to the very present issue of the shortage of staff nurses for general hospitals, certain educational implications seem clear. Since general unit patients require more nursing services than they have in the past and specialty and intensive care units have grown in number, more nurses will be required to deliver care. The generalist preparation received by the vast majority of nurses is no longer adequate to fill the roles of clinical leader and expert bedside care nurse that this new reality demands. Therefore, in addition to the usual body of nursing knowledge taught in generalist undergraduate programs, there is a need for nurses to learn even more about specialty practice. Nursing electives in the baccalaureate program provide the opportunity to the RN student to build upon the generalist base and add knowledge and abilities in a specialty. These additional courses in nursing practice assist the RN student to improve clinical judgment, which is the major difference between kinds of nursing workers of whatever category, level, or kind.

Conclusions from the Project's Work

Access to RN education appears to be universally demanded and needed. Nurses' commitment to and demand for educational mobility appear to be firmly established. Indeed, it is rare that any degree in the American educational system is considered to be terminal, including the associate degree in nursing. Nurses share in the nearly universal faith of Americans in the high value of a university or college education. Because RNs' employment potential is based on their credentials and because educational opportunities for large numbers of nurses are presently so limited, their pressure on higher education to provide the additional programs they seek can only be expected to continue. In addition, educational mobility programs and tracks are the only possible means for graduating the numbers of baccalaureate and master's prepared nurses projected to be required by the middle 1980s.

Arguments about these goals are likely to continue, particularly when this problem is viewed from the perspective of costs, but these formulations conclusively show—as the National Commission on Nursing and Nursing Education has indicated—the utter impossibility of reaching an approximation of these aims without an active and robust educational mobility plan in each state. Such planning is best effected on a statewide basis for access to RN education programs and tracks.

Nurses are also calling for opportunities for career mobility based on their beliefs of the value of educational preparation in colleges and universities, the employment potential based on the BSN degree, and the limited educational opportunities to earn this degree in the past.

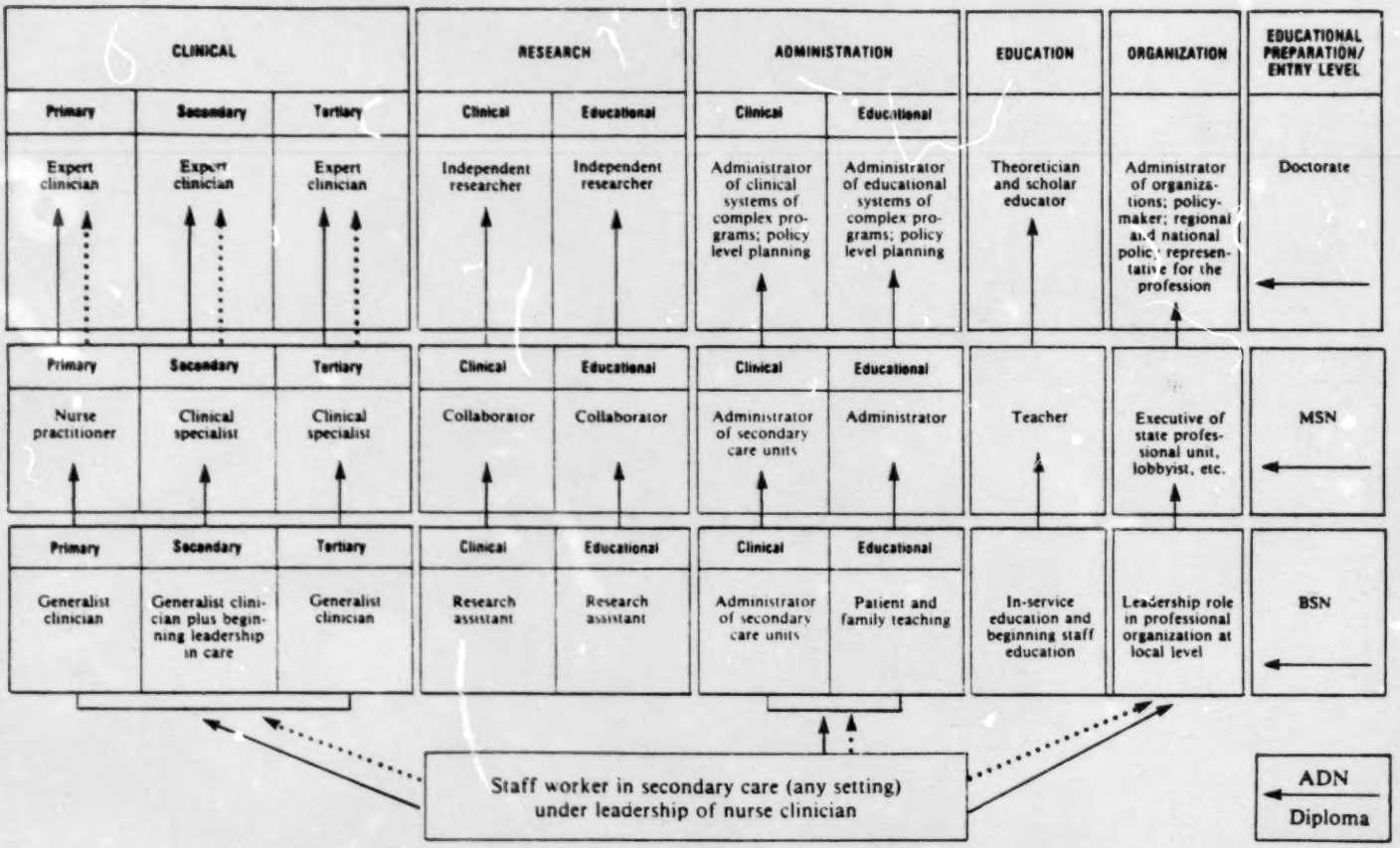
The experiences of RN students in the projects, and site visits to other RN efforts and programs, have caused the NCP project staff to endorse a variety of ways to educate RN students. Advanced standing in generic programs, "RN only" programs, satellite programs, independent study, and competency-based educational planning are all valid ways for the RN to obtain the baccalaureate credential. Each candidate for the degree should be able to choose an option that meets individual needs as a part-time working student. But clearly, we should not allow programs for RNs to proliferate without first giving thought to the kinds of institutions that can best deliver programs for the adult part-time working student. Location, institutional purposes, and student demand are all factors that must be considered during the planning stage.

Despite the cogency of arguments for extending baccalaureate opportunity to RNs, debate over the economic wisdom of increasing the educational resources allocated to these students continues. Deans at most of the universities and colleges that offer both an RN track and a generic one find that they experience higher costs than schools that offer only the generic program. Part-time students are viewed by most deans as more expensive than the full-time ones because they use as many of the university's and faculty's resources (admission, counseling, advisement, library) as do the full-time students without making as rapid progress toward earning the degree and usually without paying as much tuition. These costs may not show up in the budget, but they are measured by administrators and faculties in overload assignments without compensation.

If a nursing school elects to spend existing resources primarily on generic students, additional funds for RN tracks have to be found. With few exceptions, outreach programs have large costs per student graduated, and newly developed programs exclusively for RNs have high start-up costs. In most instances, economic pressures keep the number of RN students admitted to any one nursing program relatively low.

The economic wisdom of increasing the educational resources allocated to RN students must be weighed against the long-term cost of not educating them; it may

Categories of Nursing Practice



be very high. Because RN students represent a highly motivated group, they have shown propensity for continuing their education beyond the baccalaureate degree and/or for assuming greater responsibilities.

Wayne State University, in Detroit, Michigan, employed outside evaluators to assess their satellite efforts and found that one-third of the graduates were now seeking the master's degree, while others had moved to settings outside the hospital. Half of the graduates of the University of Maryland's outreach program for RNs subsequently enrolled in graduate programs. Others were promoted upon graduation. All were better able to interact with peers, physicians, and others concerned with their day-to-day work. Similar results were reported by all seven projects done under the auspices of the NCP.

Not every faculty works effectively with RN students, and institutions should not take on this commitment unless they are willing to examine both the curriculum and the faculty's abilities to meet the learning needs of part-time working adults. Those students who enroll immediately upon graduation from the associate degree program may not fit the classic definition of an adult learner, but most RN students have several years' working experience before matriculation. Faculty development programs are strongly recommended, as described in the experience of the projects of the University of South Florida and George Mason University.

In the NCP demonstration projects, plans for educating the working students were delineated to avoid student-teacher misunderstandings that could lead to feelings of unworthiness in both persons. A part of that plan should concern itself with the granting of credit by examination, more commonly called "challenge exams" or, by students, "testing out." Generic programs usually assume that secondary care has already been taught in the technical nursing program—as was recommended by the NCP—and permit students to test out of junior year nursing courses. In fact, in the seven demonstration projects, there was a range in the amount of coursework that could be challenged—from 37 percent to 54 percent of the nursing hours required—but substantially most of the junior year nursing courses. More than 90 percent of project students taking the challenge exams completed them successfully.

From the work of the demonstration projects and from observation of other examples of such programs, it seems clear that there is every reason to predict a high success rate for RN students who embark on a pursuit of the BSN under appropriate conditions. It also seems clear, from the varying patterns that have been found ef-

fective, that "appropriate conditions" are quite possible to provide. The need for well-planned educational opportunity for RNs reaches beyond the statistics of the moment. The mandate for higher education is explicit.

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Synopsis of SREB's Nursing Curriculum Project 1972-1981

The Southern Regional Education Board's Nursing Curriculum Project (NCP) was funded in 1972 by the W. K. Kellogg Foundation of Battle Creek, Michigan, to clarify varying nursing program goals and determine their relationship to each other. The project's specific aims were to develop a set of assumptions about health care needs, propose kinds of nursing personnel to provide the full range of services implied, and propose a blueprint for nursing education to prepare these types of nurses within the education system.

The work of this first phase of the project (1972-76) was done by a 36-member seminar which met six times over a three-year period to determine the parameters of nursing knowledge and practice, roles for various categories of providers, and directions for future development in programs of nursing education. Recommendations to achieve a congruent system of nursing education were completed in 1975.

Subsequently the Kellogg Foundation set aside $2.5 million to demonstrate the principles of the recommendations in the nursing programs of the South. Now nearing completion, the demonstration phase of the Nursing Curriculum Project (1976-81) has directly involved 22 institutions and agencies in the 14-state region of the Southern Regional Education Board (SREB). It has touched many more through liaison committees, through the work of the individual demonstration projects, and through periodic reports to the Southern Council on Collegiate Education for Nursing. This monograph, which is one in a series of final reports on the work and findings of the project, was written by Patricia T. Haase.

Staff for this phase of the Nursing Curriculum Project has consisted of: Patricia T. Haase, Director; Mary Howard Smith, Coordinator; Barbara B. Reitt, Editorial Consultant.

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PATHWAYS TO PRACTICE

Number 2 in a series of final reports on the Nursing Curriculum Project

Types of RN Programs

Registered nurses seeking baccalaureate degrees in nursing can choose from among a variety of flexible approaches, ranging from the granting of advanced standing in generic* nursing programs to the granting of an external baccalaureate degree in nursing, as done by the New York Board of Regents. Instructional designs also vary; they include: advanced standing and specially designed RN tracks in generic curricula; directly articulated programs planned between community colleges and senior universities; "RN only" programs; competency-based testing; independent study; and the delivery of a program at an outreach site. Not all of these options exist in every one of the 14 Southern Regional Education Board (SREB) states, but at least one or two are available everywhere in the region.

The question of access to these programs has been raised both by RNs themselves and the health care agencies that employ them, and it merits the attention of the educational institutions that offer nursing programs. In fact, only 1 out of 10 nurses who do not have a bachelor's degree will seek one. Whether lack of access to RN education programs or lack of incentive for nurses to pursue the baccalaureate degree is at fault remains to be seen in the data of the next decade. However this may be, the need for statewide planning for nursing education is nowhere better shown than in the issue of RN student access to baccalaureate education.

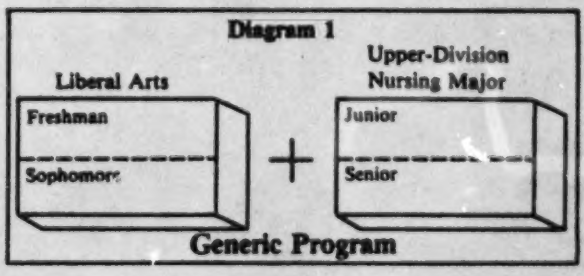
Educational mobility is compatible with each of the options in nursing education recommended by SREB's Nursing Curriculum Project (NCP) in the middle 1970s. One recommendation specifically stated that secondary care should be taught in the associate degree program, and that a core of primary care plus an elective should be added in the baccalaureate program. Regardless of the option chosen, the recommendations provide a rationale and a way to plan educational mobility from one program to another (see figure 1, page 4).

In this publication, we examine six options for mounting an RN program, describing the basic components of each and identifying some of the strengths and weaknesses. Study of the alternative types has been conducted by the NCP in conjunction with the exploration of the issues and monitoring of the seven relevant demonstration projects.†

Advanced Standing in Generic Programs

The generic program for baccalaureate students includes approximately two years of liberal arts and two years of the upper division nursing major (Diagram 1).

Diagram 1



Generic: An upper division baccalaureate nursing major built upon a base of liberal arts and sciences.

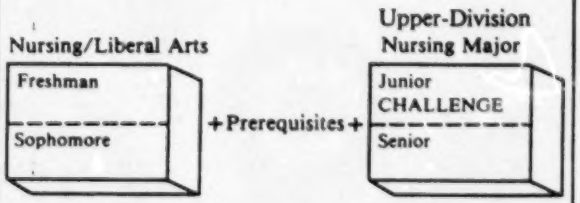
†*At George Mason University of Virginia, Medical University of South Carolina, Northwestern State University of Louisiana, Prairie View A&M University in Texas, University of Maryland, University of North Carolina at Greensboro, and University of South Florida.*

Many RN students complete their liberal arts requirements by part-time study before coming to the campus for the upper-division nursing major. The number of required liberal arts courses varies from program to program but usually constitutes about one-half of the total number of credit hours needed to graduate. Upper-division programs require that the vast majority of these credit hours be completed before the student enters the nursing major. Many of these courses can be transferred from the lower-division coursework that the student has already completed as a part of the technical nursing preparation. However, some generic programs require a number of courses in biological and physical sciences before RN students are admitted to their program of study.

If the NCP's recommendations concerning advanced standing in a generic baccalaureate program are followed, RN students will receive credit for competency in secondary care as they move into generic nursing programs. In practice, this has usually meant that students could "test out" of the junior-year nursing courses, the ones that usually instruct generic students in secondary nursing care.

This arrangement is ideal for RN students, as they may need to spend only one year in residence on campus (Diagram 2). This and other similar program plans are particularly helpful, as they facilitate the return to school of part-time working nurses who wish to pursue an advanced degree or credential.

Diagram 2



Advanced Standing for RNs

After matriculating, the RN student usually takes a required "bridge" course in nursing that is designed to facilitate socialization into a different and more complex role. Course content naturally varies, but normally all such courses introduce the students to concepts that will be used throughout their instructional program—such concepts as placing the client on the health-illness continuum, or relating human development to planning and giving nursing care.

Some faculties assign RN students and generic students to different sections or different sets of instructors—that is, they set up an RN track—while keeping the terminal objectives for both groups of students the same. Other faculties mix both groups of learners in the same classes and laboratory sections. Either pattern works well if the faculty members are enthusiastic about teaching adult learners.

The NCP demonstration projects were located in generic programs that grant advanced standing to RN students. We considered these to be good, even superior, options as the student would receive credit for what was already known and could be placed in an existing program that had (in place) carefully designed objectives for the generic graduate.

In the past, the majority of RN students have graduated from generic programs; nationally 257 programs reported 3,798 graduations last year. Fortunately, this number represents a 36 percent increase over the 1970-71 year. But when RN graduations are compared to the total number of generic baccalaureate graduates, they represent only 20 percent of the total, and this number has risen only 2 percent in the same time period. Clearly, factors deterrent to both the academic institution and the prospective RN student must be at work.

Nursing deans and directors, when questioned about the low number of RNs in their generic programs, reply that they are not anti-RN as many critics seem to feel, but are unable to expand their programs without additional resources.

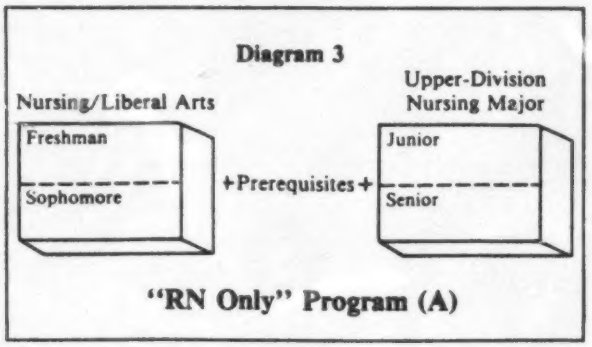
"RN Only" Programs

"RN only" programs, such as the highly visible one at California State, Sonoma, or the recently developed one at the University of Kentucky, are in the ascendancy. In fact, these programs have shown a phenomenal increase in numbers over the last several years, resembling the rapid development of associate degree programs in the late 1950s and the 1960s.

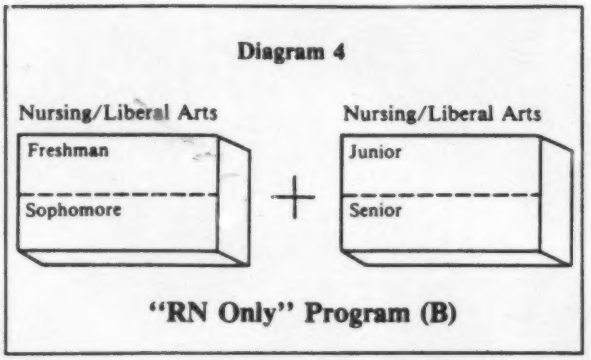
The development of the "RN only" curriculum is based on the belief that lower-division nursing programs prepare nurses with knowledge of secondary care and that a further body of knowledge encompassing primary and tertiary care can be taught at the upper-division level. In addition, as the student changes roles, changes in conceptual processes and affective interactive behaviors become necessary. The nurses' repertoires of clinical behavior are also enlarged, to include further assessment abilities, more complex problem-solving skills, and the ability to plan for future contingencies when caring for patients.

The "RN only" program is usually two years long, with a curriculum designed specifically for RN students. The curricular objectives and content should be the same as for the generic program in nursing, but they may be more difficult to develop, because there are no generic students enrolled with whom the RN students can be compared. As a result, more is sometimes expected of RN students.

The "RN only" program can take two forms. It is difficult now to know which of the two will eventually predominate. In the first form the student follows graduation from an associate degree (or equivalent) program with the fulfillment of prerequisites and the completion of the upper-division major (Diagram 3).



In the other form, the student combines liberal arts courses with nursing courses in each year of the program (Diagram 4).



Because these programs are developed exclusively for RN students, it is not possible to allow the students to challenge courses in the same way this is done in generic programs. If all students could test out of courses such as those offered in secondary care by generic programs, there would be no need to include these courses in the RN baccalaureate curriculum. The curriculum developer would then be faced with the dilemma of reducing the number of nursing credit hours required for the nursing major (often determined by university policy) or possibly offering more content addressed to different terminal objectives than those in generic nursing programs. This raises the credentialing question for some. If, in the baccalaureate program, RN students are to receive more content and greater clinical experience than the generic students, why shouldn't they receive a different degree?

The curriculum is composed of an upper-division nursing major that usually includes community health nursing, pathophysiology, physical assessment techniques, management and planning concepts, and courses on issues in nursing and health care delivery.

Clinical electives in "RN only" programs can provide an especially rich opportunity for development for students who bring a background from a clinical specialty area. Special behaviors and abilities can be structured as electives, e.g., geriatric nursing, neonatal nursing, intensive care nursing.

Since we still do not know what types of institutions can best do what type of RN program, the growth in these programs is mildly alarming: 33 reported graduations in 1972-73, and the number tripled in the seven years that followed—the NLN reported 99 programs in 1979 enrolling RN students. Apparently, a trend is in the making. In addition, there were 28,033 RN students enrolled in baccalaureate nursing programs in 1979, of whom 10,686 (38 percent) were enrolled in "RN only" programs (National League for Nursing, 1980).

Some observers feel that this rate of growth of "RN only" students will lead to a basic change in the way all baccalaureate nursing programs are structured. A change seems likely from the liberal arts base for the upper-division nursing major to an educational mobility pattern having multiple entries and at least one exit.

This belief is accented by the growing feeling among educators that the master's rather than the baccalaureate degree is the one that prepares nurses for professional practice. If this is true, then the nature of the baccalaureate program that precedes graduate study has declined in importance—suggesting that the lower division liberal arts base for the baccalaureate graduate in nursing may no longer be valued by students or their teachers.

Number of Programs Reporting Graduations of RN Students

	Generic Programs	RN Only
1972-73	241	33
1973-74	268	41
1974-75	223	28
1975-76	241	53
1976-77	253	56
1977-78	257	66
1978-79	261	99

Source: National League for Nursing, 1980.

Outreach Programs

The terms "outreach" or "satellite" were coined by educators to designate those programs that are delivered at a place other than the main campus of a college or university. Such programs have attracted much attention in nursing education because of the great demand for educational opportunity at both undergraduate and graduate levels by RNs who consider themselves placebound and educationally underserved. However, outreach programs have been particularly difficult to deliver because of their great cost and overuse of university resources.

Academic institutions have offered outreach programs in a variety of settings: on regional campuses of large universities, in state college or junior college facilities, and in area health education centers. In some instances, motor homes have been converted into traveling classrooms, audio-visual centers, or miniature libraries.

Figure 1
Final Recommendations

1 The practice of nursing at all levels is based on a body of knowledge that has at its center a set of competencies that are universally recognized as necessary to the provision of secondary care. This base of nursing, this set of competencies, should be further defined and developed.

2 The knowledge that is fundamental to each more advanced level of nursing practice is based on sets of competencies, each of which is characteristic of its own level and builds on the base of secondary care. The body of knowledge expands at each more advanced level of nursing practice and includes the different sets of common competencies necessary to the provision of primary, secondary, and tertiary care. The body of knowledge, these sets of competencies, should be further defined and developed.

3 A system of nursing education should be designed and developed to prepare graduates for different levels and types of nursing practice, a system that reflects the structure of nursing knowledge as described in recommendations 1 and 2.

4 The associate degree curriculum should be focused on the preparation of graduates to give secondary care.

5 The baccalaureate curriculum should be focused on the preparation of graduates to give not only secondary care at the beginning level, but also primary care at the beginning level and—at the student's choice—either primary care at an advanced level, secondary care at an advanced level, or tertiary care at a beginning level.

6 The graduate curriculum should be focused on the preparation of leaders to strengthen nursing's contribution to health care; therefore, graduate nursing education should be the first priority of nursing education for at least the next decade. To this end, graduate programs should be prepared to strengthen quality, expand curricular offerings, and increase enrollments.

7 Programs of higher education should incorporate continuing education as part of their regular structure, according it equitable priority in allocation of time, attention, and resources, and assigning to it faculty with academic credentials equal to faculty of other programs.

8 Programs of nursing education at all levels must incorporate flexibility in offerings, requirements, and time-and-place options for study.

9 Programs of nursing education should seek and sustain interinstitutional cooperation in order to strengthen educational services and resources.

10 Curricular structure in nursing should be interdisciplinary. Cooperation and collaboration with other health care disciplines should be sought actively by nurse educators. Where appropriate, joint courses at several levels should be developed and nursing faculty should be given joint appointments in other departments.

Nurses in areas removed from the university setting typically exert the greatest demand for these programs, but the number of nurses ready to enroll and to maintain a commitment over the long pull of the program may be fewer. Frequently, only 10 percent of those nurses initially interested will actually enroll.

Since it leads to the same degree, the curriculum offered in an outreach program should be the same as that on the main campus. Anything else is unfair to the outreach students and jeopardizes the credibility of the degree itself. The difficulty is to maintain the same quality in both programs. Another of the curricular challenges is to find appropriate cognate courses at the outreach site. Clinical experience suitable for baccalaureate students is usually available but may present a problem in small towns and rural areas.

Faculty selected to work at the satellite site need a high degree of energy. Persons qualified as instructors of outreach nursing courses are often available at the outreach location, but sometimes it is necessary to ask regular main-campus faculty to commute or relocate. Moreover, providing adequate learning resources is nearly always a problem for directors of outreach programs—not an insurmountable one, but one requiring much special attention and planning.

The Liaison Committee for the Maryland Outreach Project was able to identify nationally about 20 satellite programs at the baccalaureate level. Pat Moritz, of the Division of Nursing, N.I.H., reports 12 at the master's level currently in operation in the nation (personal communication, 1981). Given the fiscal restraints facing higher education in the coming years and the high cost of operation, it is doubtful that many new outreach programs will be developed or even that all existing ones will be continued.

Competency-Based Education

Fundamental to competency-based curricular planning is the conviction that degrees should be awarded solely on the basis of student mastery of knowledge and skills that can be demonstrated to faculty juries or evaluators. Of little concern to educators in these kinds of programs is the place where students learned the competencies or the amount of time it took them to master the knowledge and abilities.

The School of Nursing at Florida State University (FSU) initiated a competency-based program for RN students in the fall of 1975. The program, which continues today, was developed as a part of the Curriculum of Attainments Project conducted at the university from 1973 to 1976 with a grant from the Fund for the Improvement of Postsecondary Education.

FSU's plan of instruction has five basic components: (1) the identification of a set of attainments required for the degree, (2) the appointment of a jury to certify the attainment of those goals, (3) the designation of a mentor to guide students in the mastery of these competencies, (4) the use of learning packages and modules, and (5) the provision of an administrative support system.

The curriculum has been divided into 34 two-credit courses (68 credit hours) and a learning package has been developed for each of these courses. The learning activities prescribed in these packages vary widely. For example, some call for assessing a group of people for purposes of promoting health in a particular neighborhood; others call for writing and using nursing care plans for persons with varying degrees of illness; still others, for interviewing clients and conducting conferences.

A mentor is assigned to each RN student who enrolls in the nursing program to assist the student in choices of learning activities, of tutors (other nurse faculty), of clinical practice sites, and of learning resources. The tutors serve as specialists in various subject areas and as clinical role models; their assistance can be sought both by individuals and by groups of students.

When the student believes the 20 required competencies previously identified by the faculty have been attained, the faculty jury is petitioned to initiate its evaluation of performance. The testing techniques the jury uses include written examinations, clinical simulations, observation of the student's performance in direct patient care, and evaluation of presentation of the patient situation in a grand rounds format, as well as personal interviews.

The clinical simulations, the unique part of the testing process, were constructed to assist the jury in measuring the expected competencies. They were created after critical elements involved in the achievement of the competencies and the priorities of care optimal to successful performance had been identified. Clinical situations were then constructed and a script and staging for each were devised. Faculty members act out the script and the jury identifies the student behaviors that are necessary if the student is to pass this part of the examination.

The jury is composed of faculty members and nursing practitioners who have not instructed the students being examined and who can therefore be objective in their assessments. Including practicing nurses in the jury has also served to acquaint them with the competencies that can be expected of the novice baccalaureate graduate.

Another example of a competency-based curriculum is found in Texas at Prairie View A&M University, one of the NCP's demonstration sites, where the College of Nursing developed learning modules for students needing to acquire specified competencies or attain given objectives. The theoretical base for this instructional system is Benjamin Bloom's concept that mastery of a subject can be achieved by most students if they are given appropriate instruction and sufficient time. In a system such as this, aptitude is viewed as the time required to master the objectives. Students were considered successful if they mastered the objectives. If learning had not occurred, the instruction for the sequence was revised and the student recycled through the revised system until able to demonstrate that sufficient learning had taken place.

The steps that are followed in modular instruction are: (1) to formulate objectives or competencies, (2) to develop the modules, (3) to conduct a pre-assessment of students' abilities, (4) to have the students complete the modules, (5) to conduct a post-assessment of the students' abilities, and (6) to revise the package to promote students' success if learning has not occurred.

Independent Study

Independent study combined with competency-based testing has been particularly attractive to nurse educators during the last decade. The form of study is admirably suited to RN students who are place-bound and highly motivated. They typically prove themselves to be able to gather and synthesize their own sets of information and develop their own clinical abilities. For this reason, the New York External Degree Program for both baccalaureate and associate degree students has been of special interest to nurse educators who are looking at career mobility options. Most Southern states accept the external degree as sufficient preparation for the licensing examination.

Students who choose to enroll and complete this program master independently the coursework that is required. Many of the students who have completed the New York External Associate Degree Program and have been licensed to practice have a prior history in another nursing program (diploma, associate degree, or baccalaureate) but failed to complete the course requirements. The External Degree Program has also attracted people who have received training in the military but who have no credential to certify their accomplishments.

Course credit is earned by completing paper-and-pencil tests in both nursing and cognate courses. It is also possible to transfer earned credit from academic institutions elsewhere to the New York External Degree Program. After satisfactorily completing the competency-based written testing program, the student is eligible to take the clinical proficiency examination. For this phase of the examination, the student must travel to a clinical testing site, which provides the opportunity to demonstrate skills in the laboratory and on the hospital unit in the actual care of patients who have been selected by the evaluators on the basis of pre-determined criteria. Baccalaureate tests also include the use of televised vignettes and the evaluation of the examinee's health assessment examination of patients who are paid for their services.

The External Degree Program for both the associate and the baccalaureate degrees consists of prescribing learning activities and testing the candidate for the accomplishment of specified objectives. Its structure for the baccalaureate is shown in Diagram 5.

Diagram 5

RN Credential (Diploma or AD degree)
+
Transfer and/or Testing Program for Liberal Arts Requirements
+
Testing Program for Upper-Division Nursing Major

External Degree Program (B.S.N. Degree)

From this brief description of the New York External Degree program, it will be appreciated that not every student could be comfortable with it. Many would prefer a learning situation that provided more guidance and was more closely monitored. There is also the consideration that the candidate must defray the cost of travel to the testing site, lodging while there, and the substantial fee for the clinical examination. However, for RNs who can handle these expenses and who are highly motivated, self-starting, and resourceful, as many of them are, the external degree program presents an option extremely well adapted to their needs.

Directly Articulated Programs

Another pattern for RN programs involves planning between two or more institutions for direct articulation between lower-level programs and higher-level ones. An example of such interinstitutional planning has been described in the publication about the Orange County-Long Beach consortium in southern California. In 1971, a consortium of schools was formed and funded by the W. K. Kellogg Foundation, with the purpose of breaking down any barriers existing between and within schools so that opportunities for nurses to start, stop, or move up the educational ladder could be provided. The result was a multiple-entry, multiple-exit consortium that now includes five community colleges and two universities. Together, the seven schools prepare licensed vocational nurses, registered nurses at the associate degree and baccalaureate levels, and specialists at the master's level. Choice was planned as an inherent part of the program, and at the associate degree and baccalaureate levels there are both generic and career ladder options.

The plan is particularly pleasing to recent associate degree and practical nurse graduates, who can move up the career ladder in increments usually of two years' academic and clinical work. If the student chooses to progress by two-year increments, the program can properly be called a "2 + 2" program. This simply means that the graduate spends two years in the first program and an additional two years in the next higher program. (However, the term "2 + 2" has several meanings and can refer to two years of liberal arts and two years of a professional nursing program.)

The goals of the consortium were attained by improving communication between the nurse faculties, joint planning for common terminal objectives, and establishing new programs to create a smoothly operating educational system offering every contingent of nurse education from practical nursing to nursing at the master's level.

According to Lysaught (1981), the consortium plan for mobility has not stifled initiative among the participating schools. Long Beach City College and Cypress College each have three nursing programs: one to prepare practical nurses, a second to permit practical nurses to earn the associate degree, and a third to allow qualified high school graduates to earn the associate degree. Three other associate degree programs at different institutions have similar offerings but not all three options (Lysaught, 1979).

At the higher level, there are two universities. One provides a baccalaureate program for registered nurses only and the other a generic baccalaureate program plus the career ladder option for RNs. The master's degree program accepts students from several baccalaureate programs but uses the curricula of the consortium schools as models in setting prerequisites.

The directly articulated program of the Orange County-Long Beach consortium, which has been illustrated in a publication of the W. K. Kellogg Foundation, resembles the following diagram (Diagram 6). Seven different institutions are involved in this multiple-entry and -exit plan.

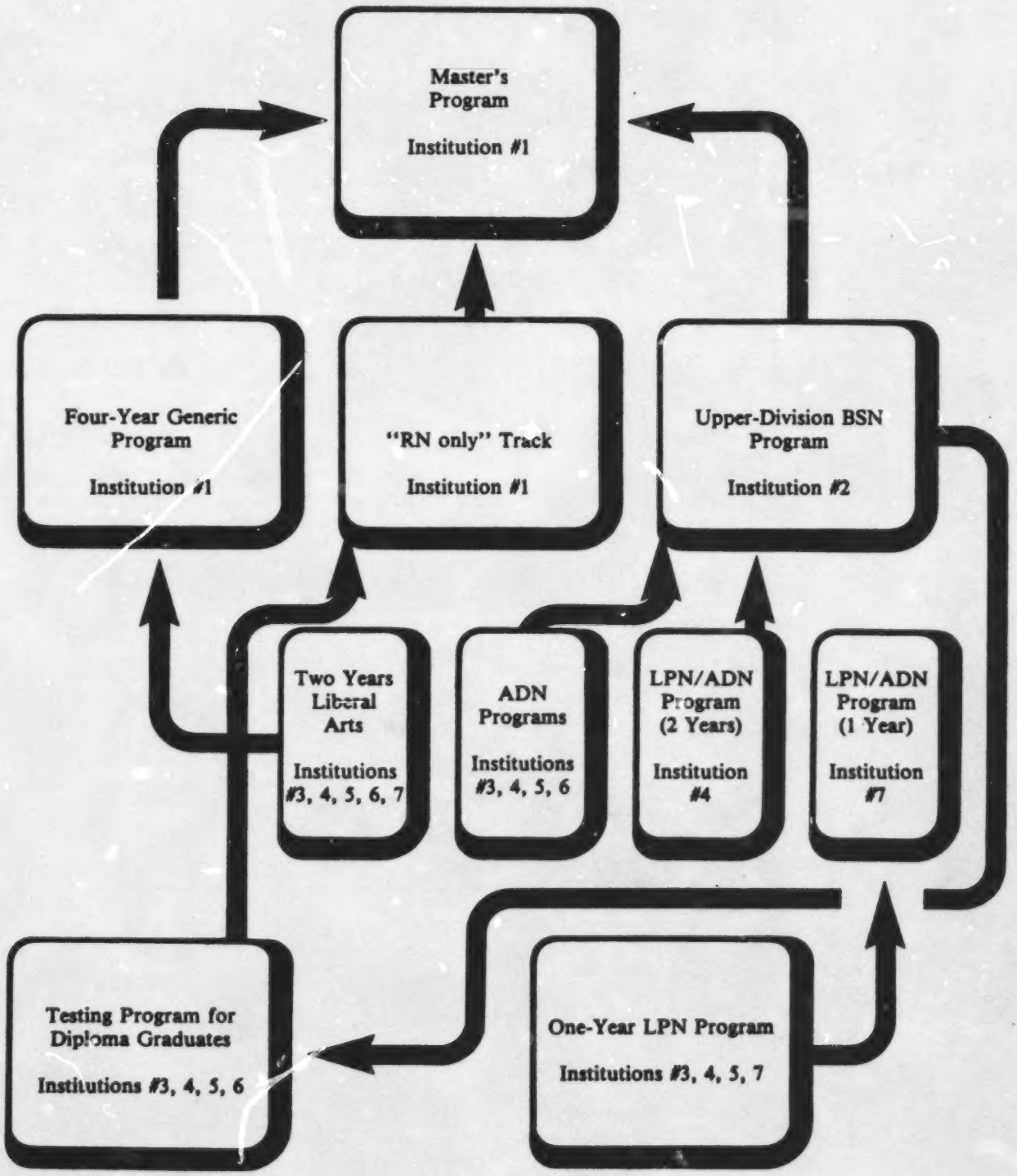
More such formally organized multiple-entry, multiple-exit programs are not in place, most probably because of the difficulties of getting them developed and keeping them operational after they have gotten underway. Persons who have been involved in the Orange County-Long Beach project agree that a tremendous amount of faculty and administrative time is required to work out equivalencies between and among curricula and to keep the several programs "in sync" with each other. They also agree that the effort is rewarding. However, in view of the complexities of the multi-institutional program, informal articulation arrangements are more common.

Conclusions

Over the past five years the NCP staff has had an opportunity to become familiar with the experiences of the students in the seven RN demonstration projects and to make site visits to other RN efforts and programs. Conclusions from these observations cause the staff to endorse multiple pathways to baccalaureate education for RN students. Advanced standing in generic programs perhaps permits the student greater freedom in the completion of non-nursing courses and an opportunity to challenge the secondary care portion of the curriculum. However, it is unrealistic to expect that our present generic programs can accommodate the large number of registered nurses wishing further education. "RN only" programs, outreach programs, independent study, and competency-based curricular planning are other valid ways for the RN to obtain the BSN credential. The nurse seeking the degree should be able to choose an option meeting her/his own needs as a part-time, working student.

At the same time, it seems obvious that programs for RNs should not be allowed to proliferate without attention to the question of what kinds of institutions can best deliver what kinds of programs. Factors that must be taken into account are location, institutional purposes and resources, availability of clinical facilities, and student demand. The importance of all these variables for decision-making underlines the desirability of statewide planning for RN education.

Diagram 6



Institution #1 State University
Institution #2 Second State University
Institutions #3, 4, 5, 6, 7 Community Colleges

Directly Articulated Programs

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PATHWAYS TO PRACTICE

Number 3 in a series of final reports on the Nursing Curriculum Project

RN Programs: The Right of Passage

Planning and Operating an RN Program

An Outline for Effective Planning

During the 1970s, nursing education bore increasing pressure, both from within nursing and health circles and from without, to provide better educational opportunities to licensed RNs who wish to earn a bachelor's degree. A few facts about the recent spurt in the growth of RN education reveal how intense the pressures have become. About 6,500, or 20 percent, of the nearly 32,000 nurses graduating from baccalaureate programs in 1978-79 were registered nurses. This number marked a 36 percent increase over 1970-71, when just under 4,000 RNs received bachelor's degrees (National League for Nursing, 1980). Despite this growth, it is suggested that this number is not enough. Clearly, wise planning is greatly needed.

However, before nursing educators and administrators can make the best decisions about mounting new RN programs, they need to do more than ponder the issues and the theoretical models. (In "RN Education: The Basic Issues" we discuss the issues surrounding the concept of degree programs for registered nurses; in "Types of RN Programs" we describe models for the major types of programs currently offered.) Educators and administrators need also to examine the practical problems involved in designing and executing such programs and to seek out measures that have proven to be effective in some of the more successful ones. This publication by the Southern Regional Education Board's (SREB) Nursing Curriculum Project (NCP) was written after monitoring seven demonstration projects* undertaking programs for RNs and after studying many more. It is designed to supply basic information on planning and operating an RN program.

Feasibility Studies

Because budgetary resources for any nursing program are finite, planning is essential if funds are to be managed equitably to serve the needs of both generic† and RN students. Before embarking on any of the options that are available, planners are advised to make a feasibility study.

Although there may be exceptions, most programs of nursing education do not contemplate starting any kind of RN program until requests begin coming in for them to do so. A feasibility study should first concentrate on determining whether the apparent demand is widespread or is actually coming from a vocal minority of the RNs in the area. If the demand is indeed general, the study needs to ascertain the reasons for it. The reasons may suggest alternate solutions. If a high demand for more spaces in a generic program is coming from RNs, it may be simply that a deficit of opportunity has been backing up for a number of years and all that is needed is a special, time-limited effort to meet this accumulated demand. Or, the demand may be larger than the pool of genuinely qualified applicants. Unfortunately, many nurses who request courses are unable to take advantage of them when they are offered. Of course, care must be taken to differentiate the reasons RNs do not take courses they had sought. It is one thing when applicants prove to be unqualified or not ready to make the commitment involved in undertaking a course of study, but quite another when scheduling and timing prove to be the problem.

At the Medical University of South Carolina, Northwestern State University of Louisiana, Prairie View A&M University, University of Maryland, University of North Carolina at Greensboro, and University of South Florida. George Mason University conducted a related demonstration project consisting of workshops for nursing faculty interested in RN programs.

†*Generic program: An upper-division baccalaureate nursing major built upon a base of liberal arts and sciences.*

Outreach programs in particular need to make prior studies because of their expensiveness and because they are likely to have few "payoffs" in large numbers of graduates. Although many voices are heard about the need for the outreach programs, the experience of existing projects indicates the wisdom of caution. Usually only 10 percent of those nurses initially interested will actually enroll. For three programs known to members of the Outreach Liaison Committee in the NCP, the experience was: 100 interested, 15 graduated; 100 interested, 13 graduated; 150 interested, 14 graduated.

The director of a feasibility study should next consider whether a new "RN only" or outreach program could receive the approval of local, state, and regional planning bodies, which assess the need for additional educational programs and seek to prevent the duplication of services. Data about the existing nursing pool and projected nursing practice requirements should be available to planners. It is especially important to check early for possible duplication of educational efforts that may be in the planning stages by other schools. Feasibility studies must weave into their own projections the likelihood that competing programs will not be approved by educational and health care planning bodies.

Additional subjects needing close attention in a good feasibility study include an evaluation of the future market for nurses prepared at the baccalaureate or master's degree level and an assessment of the rewards available to graduates of the projected program, for example, increased salaries or improved opportunities for advancement.

Most important is an evaluation of the receptivity of the community's health care personnel, including leaders in agencies and private practice. If such persons are brought into the planning early, their support is likely and, furthermore, appropriate preceptors and clinical sites can be identified. It is also important to know that people who currently employ prospective RN students support the idea of their returning to school. Crucial questions for planners to ask include: Will there be a plan in some agencies for tuition assistance? Will flexible scheduling of hours of work be possible? Can the students expect increased salaries upon completing the degree? Can they expect promotion to a job requiring additional clinical or managerial skills?

Another important consideration for those conducting a feasibility study is the availability of clinical learning experiences. Occasionally, a need for RN education coincides with an overload in clinical agencies of other kinds of students—those in practical nurse, associate degree, and generic baccalaureate programs. Because a scarcity of clinical learning sites can effectively cripple an otherwise sound program, the feasibility study should look long and hard at this question. The quality of the clinical program is of paramount importance to the graduate's ultimate success.

Outreach sites wishing to have a program started also should determine the availability and cost of certain resources. Many kinds must be considered: local educational facilities for transferable courses in the sciences and humanities, clinical practice sites, office space, classrooms, living accommodations for commuting faculty, libraries, and such support services as suppliers of audio-visual equipment, nursing laboratories, computer centers and computer terminals, and independent study opportunities. Moreover, all faculty members experienced in outreach programs emphasize the need for careful analysis of transportation that would be available to teachers commuting to the outreach site.

The impact on existing instructional support systems needs to be evaluated, whether the projected program simply adds to the student load on the main campus or develops a new satellite site. Planning for an effective communications network and counseling service is a first priority. In fact, several educators believe that good counseling is the key to success in any RN program.

Funding

Sound financial planning for RN programs is the most important ingredient in their ultimate success or failure. Many outreach and other RN programs have been funded on "soft" money and have died out when the original grants were spent. Permanent funding should be sought from the beginning. Grants may be used to start RN programs, but a plan for replacing them with secure, ongoing funding sources must be assembled so that the quality and quantity of nursing education and health care available to a community can be protected. Indeed, some educators feel that in the absence of "hard" monies, a project should be deferred until the institution is willing to commit a portion of its budget or to generate new funds to support it permanently.

Another possible approach planners can take is to adopt the "self-destruct" mechanism, by which an experimental program is mounted for a specified period of time. However, no real evaluation of such planning has yet been attempted.

Deans of generic programs feel that RN students are more expensive to educate than traditional students. RNs usually attend school part time while working and seem to consume as many resources as the full-time campus students. They also require the same advisement and counseling, the same support systems, and the same teaching time as do generic students, who proceed in a more orderly fashion through the curriculum. For an RN program, faculty released time must be provided for such activities as: (1) giving and grading competency-based testing (both written and clinical), (2) planning for teaching techniques different from the ones usually successful for generic students, and (3) developing instructional materials that can be used in nontraditional learning programs. In addition, there must be funding for the position of RN coordinator or facilitator—money that often is difficult to obtain.

Planners should also recall that in RN programs faculty time is also absorbed with clinical teaching that calls for the same student-faculty ratio (usually 1:10) as for the generic student but that offers no payoff in an increase in the total number of practicing nurses. Furthermore, there is the difficulty of advising RN students when the nursing department is staffed with teaching positions only and

does not have budgeted positions for counselors nor provide a facilitator or administrator for the RN program. Finally, because of the part-time attendance of many RN students, the advising load often doubles without a matching increase in faculty size or in budgetary allowances.

In the 1960s, RNs began pressuring legislators to require the educational system to offer the career or educational mobility option. Laws in California and Arkansas have been enacted to facilitate the movement of students upward in the educational system. However, many other legislatures have resisted the funding of outreach programs and several states have prohibited the use of general fund money in off-campus activities. In instances like these, the typical net effect for RN students is a large tuition hike. Because public funds are often hard to come by, RN programs are even more difficult to put into place unless grant funds are available.

Feasibility studies, when well done, can reveal important issues for planners to consider. Whatever the precise form of RN education a group of planners may envision, they need to be certain that the university is receptive to using resources in such nontraditional ways as outreach programs or flexible time schedules. If the university administration or the nursing faculty have other priorities, then it is better not to undertake, for example, a satellite project. An RN or outreach effort must be as much a part of the college of nursing as the junior or senior year curriculum for students in residence. And faculty must be as supportive of an RN effort as they are the quality of their generic program.

Curriculum

Unless curricular design ensures that an RN program meets the same objectives as the one developed for generic students, the two groups of graduates are really not getting the same degree. If courses planned for RN students go beyond that parameter, they should carry *both* graduate and undergraduate credit. When planning "RN only" curricula, administration and faculty sometimes expect more of RN students than they do of generic ones, a tendency that is unfair to the registered nurses.

Specific curricular patterns are described in the forthcoming SREB publication of the Nursing Curriculum Project, "Reports of Seven Demonstration Projects." The usual pattern for the RN track for nurses enrolled in a generic program is (1) to provide "bridge" courses between the student's initial education and the baccalaureate program, (2) to permit the student to challenge the junior-year nursing courses, and (3) to arrange for matriculation for the senior year in residence. A course of this nature was an important part of the practice in all seven NCP demonstration projects, and seems to be the general practice in other schools also. "Bridge" courses address the issues taught in the baccalaureate program in the junior year to which students have not yet been exposed and usually include such concepts as physical assesment abilities, nursing process information, quality assurance and peer evaluation concerns, crisis and change theory, human development, patient teaching and counseling, research and pathophysiology, to name a few.

Usually, "RN only"curriculum development is isolated from that for generic students. It is typically predicated upon a faculty's interpretation of the objectives for baccalaureate education in nursing. "RN only" curricula have seldom been described in the literature, with the notable exception of the curriculum for the Sonoma program (Searight, 1976, pp. 40-43). Programs are usually two years in length and have several electives that the RN student can challenge.

A persistent problem for the outreach curriculum is the maintenance of quality in comparison with the program offered on the main campus. One solution is to have at least some of the same teachers on and off the campus, to orient new teachers to the on-campus program, and to have faculty at the outreach site work closely with the coordinator of the course on the campus. Another solution is to move the students back and forth between the outreach site and the main campus. A related problem is finding appropriate cognate courses at the outreach site. Even more important is the provision of clinical experience for the student, which can be an acute problem in small towns and rural areas. The consequence may be very small numbers of students enrolled in any one clinical specialty and limitation of the clinical specialties that can be offered.

Considerations that need to be dealt with in assessing feasibility and progressing to planning have been listed in a set of "Guidelines for Establishing Undergraduate or Graduate Programs Off Campus," developed by the Liaison Committee for the University of Maryland outreach projects (see p. 4).

Operating an RN Program: Issues for the Planners

Once the decision has been made that an RN program is feasible and desirable, and the curriculum has been planned in principle, there are operational problems that need to be taken into account well in advance of the program's opening. Many of these problems are reasonably simple to solve if they are anticipated during program planning. They relate to challenge examinations, classroom and clinical teaching strategies, time and place options, advisement and counseling, differences of RN students from generic ones, and faculty attitude and satisfaction.

Challenge Examinations

Nursing programs are to some extent governed by general university policy in transferring and granting credit by examination; there are probably as many variations of these policies as there are academic institutions. One generalization may be safe: most places accept some amount of credit under certain conditions for arts and sciences courses via the College Level Examination Program (CLEP) and/or teacher-made tests. However, credit for nursing courses, or provision for "testing out" of them, constitutes a more difficult problem for both the school and the applicant.

Competency-based testing presents a challenge to both administrators and faculty. The first question a faculty asks itself is how to arrange its integrated curriculum to permit anyone to test out of anything. This can be a severe problem because the baccalaureate program in

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Guidelines for Establishing Undergraduate or Graduate Nursing Programs Off Campus*

Main Areas of Consideration

A. Assessing the Need

1. Evaluate the impetus
2. Estimate the market for BSN- or MS-prepared RNs
3. Evaluate the rewards available after completion of degree—salary differential, potential for promotions, etc.
4. Estimate the number of RNs wanting a BSN or MS
5. Estimate the number of RNs ready for enrollment in a degree-completion or graduate program (approximately 10-15 percent of those interested finally enroll)
6. Assess the possible duplication of nursing education programs in place or proposed by other schools
7. Estimate the future pool of students from local nursing programs
8. Evaluate the need for short- or long-term program.

B. Assessing Resources and Barriers

1. Estimate initial and ongoing funding resources—a portion from general (not grant) funds is imperative
2. Evaluate faculty commitment and community resources (university, school of nursing, local nursing, and other)
3. Assess general education facilities for local transferable courses
4. Indentify clinical practice sites for use by an additional program
5. Assess physical facilities (offices, classrooms, libraries and their resources, support services, labs, TV, computer centers) for availability and cost
6. Analyze transportation systems available to students for distance, road conditions, safety, parking, public means, and costs
7. Assess local receptivity to a program in nearby HSAs, schools of nursing, hospitals, health departments, and other agencies
8. Determine support in employment settings for RNs returning to schools (tuition reimbursement, flexibility of scheduling, salary increases, etc.)
9. Assess local communication/coordination groups and publicity resources (including official and unofficial liaison contracts, district nurses' associations, nursing education and service councils, health planning councils, radio and TV stations, newspapers, interested individuals)
10. Evaluate living accommodations for outreach faculty.

C. Planning

1. Identify program planners and place of program in organizational structure
2. Establish time frame for planning, implementation, and evaluation of the program
3. Visit and consult other outreach programs
4. Review accreditation guidelines
5. Review funding guidelines and consult with representatives from funding organizations
6. Appoint advisory committee
7. Design off-campus program to meet objectives of the on-campus curriculum
8. Develop educational strategies for implementing the design; include program calendar
9. Design evaluation plan
10. Establish admission and progression policies (transfer of credits, challenge exams, time frame for completion of degree, credit for experience, etc.)
11. Develop instruction and noninstructional support systems (communication system, library services, audiovisual resources, tickets to events, parking, malpractice insurance, health services, registration procedures, tuition and fees, financial aid, etc.)
12. Conduct preliminary negotiations for facilities, resources, services
13. Identify potential faculty and special lecturers
14. Identify liaison person
15. Identify public relations resources and develop materials
16. Develop budget with justification
17. Write final proposal.

D. Implementation

1. Publicize the program
2. Recruit and orient personnel
3. Establish and regularly assess communication network
4. Recruit students; establish commitment to completion of degrees
5. Institute student advisement and placement
6. Implement design
7. Contract for education/clinical facilities in the local area
8. Maintain calendar of projected course offerings.

E. Evaluation

1. Institute ongoing evaluation of students, faculty, curriculum, courses, resources, attainment of program objectives, etc.
2. Assess cost-effectiveness
3. Prepare cumulative evaluation, including need for continuation.

**Developed by the Liaison Committee of the Outreach project of the University of Maryland.*

nursing is so often unique to a particular institution. One solution is to administer the Proficiency Examination Program (PEP) tests in nursing, which were originally developed by the New York External Degree Program and are now available through the American College Testing Program (ACT). Another solution, often preferred by the baccalaureate program that considers itself atypical, is the use of teacher-made tests. Obviously, either alternative has advantages and disadvantages that must be weighed by a given faculty before a choice is made.

Clinical examinations present still other problems. Conducting real or simulated hospital situations or home visits with each applicant is enormously time-consuming and involves scheduling difficulties. Video cassettes presenting clinical problems can reduce these, but the cost involved in their preparation (considerable) or purchase (much less) can pose still other difficulties. Finally, inter-rater reliability on the part of examiners is a problem in all these measures.

The New York External Degree Program (NYEDP) demonstrates the fullest use of examinations for the purpose of establishing credit. The NYEDP defines itself as a non-instructional *assessment* program, awarding degrees for learning acquired elsewhere. Candidates may establish credit by taking courses at accredited colleges or by using standardized proficiency examinations to validate the acquisition of learning through independent study and experience; the candidate organizes the program of study to meet degree requirements. As might be supposed, successful candidates are highly motivated self-starters with initiative and self-discipline. The external degree in nursing requires a clinical examination that takes several days, with the student bearing the costs of travel to the test site, lodging, and the substantial examination fee. Clearly, this is in no sense a "cheap" degree and not every student is temperamentally suited to its methods. Its clinical examination system, however, embodies principles and methods that can be adapted by schools providing RN tracks. Four of the demonstration projects* studied these at close range before completing their examination plans.

The RN is likely to seek out a structured program close to home. And schools offering a track or special program for RNs have to set policies governing admission and progression, transfer of credit, the granting of credit for life experience, and the uses and costs of challenge examinations.

Teaching Strategies

A faculty developing an RN program or track has to consider how to teach the adult learner effectively. Houle has identified several characteristics of the adult learner that can be used in planning appropriate teaching strategies (cited in Knowles, 1975). First, nothing so disturbs beginning adult students as the fear that they will not be able to learn. Second, being in the prime of life, they think they ought to learn without effort or strain. Third, their learning is strongly influenced by the point of view they bring to it. Fourth, their greatest asset is their experience, which enables them to see relationships,

**Northwestern State University of Louisiana, Medical University of South Carolina, Prairie View A&M University, and the University of North Carolina at Greensboro.*

understanding new concepts in terms of the perspective their backgrounds give them. Knowles adds that the adult student is more motivated by the demands of social roles and more interested in the immediate application of knowledge and skills.

Atypical time and place options

Adult students are usually employed and/or have family responsibilities, so as students they require special time-place options. Night classes, weekend classes, mini-mesters, and "summers only" programs are particularly suited to their needs. Each of the NCP demonstration projects addressed these special needs, employing arrangements that ranged from Saturday classes to the delivery of an entire program at a satellite site.

Academic advising and counseling program

Adults are particularly apt students for strategies that permit educators to make in-depth analyses of their learning needs and style so that an individual learning program can be prescribed for them. The project faculty at the Medical University of South Carolina developed such an approach especially well. The outreach programs at the Universities of Maryland and South Florida developed entire student support systems to include communication systems, library services, audio-visual services, malpractice insurance, and health services.

Support systems are important tools in dealing with student problems; if well designed, they reinforce proper behaviors as students learn new roles. This is the reason the students in the University of Maryland project were required to come to campus for one course during their work toward the degree. Those in the first class that graduated from Maryland were not required to do so and consequently felt isolated. Other NCP demonstration programs used other techniques, such as holding Saturday seminars, distributing newsletters, and holding research conferences to be attended by several student groups within one university or from several institutions.

Alternate ways of teaching theory

Several NCP projects constructed modules (limited, self-instrucional learning packages) for students, designing them to accomplish various specific purposes. The entire Prairie View and South Florida curricula were modularized, but other programs used modules only for portions of courses.

Teachers of RN students at both on-campus and outreach sites have creatively employed a variety of technologies, including video cassette, mobile vans, satellite transmission (costly), tele-lectures, packaged instructional modules, FM sub-channel radio, computer-assisted instruction with portable terminals via telephones, and many have experimented with such new techniques as independent learning contracts and, at Florida State University, the jury method of evaluation.

Several programs have successfully used tracking, that is, teaching RN students in different sections of a given course rather than in the same sections with the generic students. Tracking also permits the structuring of seminars for individuals sharing like experiences and backgrounds.

Traveling scholars can help make satellite efforts succeed. The most expert of the home school faculty can be brought to the outreach site from time to time, supplementing faculty resources on the site. In the University of Maryland project, home school faculty were part of the instructional program on an ad hoc basis.

Alternative methods of clinical teaching

Among all assumptions about teaching, those concerning clinical teaching are the most controversial. The greatest problem is the clinical testing used for granting RNs advanced standing in the program; several NCP projects developed such a test. A second problem is the work-study option, addressed by both the Northwestern State University of Louisiana and the Medical University of South Carolina projects. In fact, the use of the work place as the clinical learning laboratory is the newly emerging alternative to traditional clinical teaching strategies. Such an approach requires cooperation among nursing administrators, hospital personnel, and nursing faculty, with careful prior and ongoing planning. The Northwestern Louisiana project describes its experience with such an arrangement in "Reports of Seven Demonstration Projects," illustrating that when such use of the work place is feasible, a number of advantages accrue to students and faculty alike. Several NCP demonstration programs confirm that finding with analogous plans. The South Carolina project, for example, used clinical specialists as preceptors and clinical teachers, reporting that these faculty members were particularly well-liked by the RN students. The practice gave a special meaning to the joint appointment the specialists had with the College of Nursing. Prairie View faculty, in cooperation with local physicians, developed a free clinic to provide the necessary primary health care experience for their RN students.

Students

The student in an RN program is typical of all adult learners. In the NCP projects, the typical RN student was about 30 years old, had from 5 to 10 years of experience, and was employed. Many of these working women were married with families; some were single parents. They were returning to school because they wanted more individual freedom, which they felt they could achieve by broadening their perspectives and experiencing the challenge and intellectual stimulation of the university environment. In addition, in their pursuit of career goals, they were determined to increase their competence and sense of mastery, seeking professional advancement on their own terms. In sum, they wanted not only a greater confidence in their own identity and a better direction in the world of work, they also wanted to be better nurses.

But as alike as their fundamental purposes might be, RN students vary in the emphasis they give to specific goals. Some seek only to enhance their sense of self-confidence. Some, wanting a new beginning, seek second careers; others wish only to complete unfinished business. Others want to move forward financially, and still others profess their intention to pursue specific valued interests inherent in their life's work.

RN students as a group represent more diversity in life situations, previous experience, skills, intellectual capacities, and styles of learning than most nursing faculties are accustomed to acknowledging and planning for.

Faculties usually select nontraditional approaches for RN students. Knowles' (1975) description of these approaches serves as a warning:

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> Many of the new developments in education—the new curriculums, open classrooms, nongraded schools, learning resource centers, independent study, nontraditional study programs, external degree programs, universities-without-walls, and the like—put a heavy responsibility on the learners to take a good deal of initiative in their own learning. Students entering these programs without having learned the skills of self-directed inquiry will experience anxiety, frustration, and often failure, and so will their teachers (p. 15).

Before the student selects a program, learning goals and style should be evaluated to protect the school from attrition and the student from the loss of self-respect. Students who prefer more structured settings and instruction should not be encouraged to undertake an independent study program. In fact, the student's selection of the right program appears to be the key to a successful passage from the associate degree or diploma to the baccalaureate.

Many adult students have initial difficulty in adjusting to student status in the back-to-school regimen, and RNs are no exception to this rule. Regrettably, it has become a cliché among some baccalaureate faculties that RN students are hostile and resentful. Whether "hostile" is the proper word to describe the feelings of the students can be questioned, but there is little doubt that in some programs these students are intially angry and anxious.

Just how widespread these beginners' reactions are must be left for a structured study, but they seem to be typical of RN students before the beginning of the 1970s, when as a group they began to receive special attention. A typical response has been reported by Portnoy (1980). RNs in her program experienced "...some anger about the rearrangements and adjustments we had to make for this program. Some of us had sacrificed important aspects of our personal and professional lives that had given us great satisfaction in the past. At this point we felt we had received little in return" (p. 114). But stereotypes die slowly and some RNs continue to believe that artificial barriers have been placed in the way of their progress, obstructions such as repetition and irrelevant coursework.

In a widely read paper, Woolley describes the reaction of some of her RN students as surprising, disappointing, and exhausting to the faculty who worked with them.

> They participated minimally in class, although they were encouraged to do so, and actually had much to offer. They were passively resistant to involvement in new ideas under discussion and resorted to that ultimate student weapon, sullenness.
>
> They held class meetings at which they complained about the amount of work, methods of teaching, and personalities of faculty within the program. They made no efforts to discuss their problems with the faculty but, instead, went to the dean of the division with their complaints....They gave all faculty very poor evaluations, even those of whom they had informally expressed approval (Woolley, 1978, p. 104).

Fortunately, students in the NCP projects did not react this way. Faculty were amazed in some instances that no hostility was displayed. The actual experiences of several projects are described in "Reports of Seven Demonstration Projects," but suffice it to say that teaching strategies for the adult, part-time, working student were planned and used in such a way as to enhance students' self-respect and to promote learning.

After the initial adjustment period, the RN students did become more independent learners who used faculty resources in different ways than generic students. They were usually more practical in their outlook and highly goal-focused. And they brought a rich background upon which to build a rewarding future. Faculty members who desired the success of these students enjoyed teaching them more than other students.

Initially RN students in the projects wanted structure in their learning experiences. As Knowles has said, "Many students enter into a new learning situation feeling a deep need for the security of a clear structural plan—an outline, course syllabus, time schedule, and the like. They want teachers who know what they are doing, who are in charge" (1975, p. 37). And it was indeed difficult for many students to adjust, as they must, to a teacher who was a facilitator and to a structure oriented to process rather than content. It is, according to Knowles, a tragic fact that most of us know how to be taught, though we have not learned how to learn.

The RN students make many personal sacrifices to attend school and, as is characteristic of adult learners, sometimes become overcommitted before realizing the difficulty of the program. Some students feel that they will not need to study because they already "know" nursing or believe that they can continue to work on a full-time basis. Needless to say, such students are reluctant to take challenge examinations.

Faculty with experience in RN programs feel that their students must have support systems to reinforce the proper and expected behaviors as they learn new roles. This is the reason for the University of Maryland's requirement, mentioned earlier, that the outreach students come to the campus for one course. At the University of Alabama at Birmingham, support systems take the form of Saturday seminars, newsletters, and a research conference with Emory University in Atlanta, the University of South Florida, and the University of South Carolina.

Attrition data for RN students are hard to come by except on a school-by-school basis. At the University of Maryland the attrition rate is quite low; at other schools the rate varies at somewhat higher levels. The national figure is difficult to calculate because most of the students are part-time and take several years to complete their program. Wilson and Levy (1978) did a study of attrition at Sonoma State College in California, presenting their findings by adopting a holistic perspective in their study. They took into account the students' life roles, influences, and responsibilities beyond the nursing program and concluded that attrition in RN programs was being caused by the interaction of self-image, values, and capabilities that produced varying degrees of commitment to the program.

Faculty

Despite the importance of the subject—most authorities agree that faculty members' positive feelings are critical to the student's success—the literature on faculty reaction to baccalaureate education for RNs is practically nonexistent. Woolley quotes one faculty member as saying that "those who work with this group

deserve a special place in heaven" (1978, p. 103). Other observers report similar comments; faculty members sometimes complain that they need an additional "energy increment" to work with these students, some say they deserve a "salary increment" for "hazardous duty."

When asked about this anger and anxiety, some teachers of RN students replied in this vein: "The student is a clinical threat to me." "These students mean a work overload for me." "No wonder I'm angry, it's reciprocal." "Who wishes to risk bad evaluations?" (Obviously, the latter refers to promotion and tenure.) One dean said that the faculty she worked with wanted to teach novices and not "old warhorses."

Negative faculty response, if sometimes unfair, is often quite understandable. A dean gave the example of the RN baccalaureate student who was a nationally known expert in critical care nursing, a regular speaker at national workshops and conferences. Naturally, her instructors found this student to be threatening; what could they teach *her*, clinically? Reasonably enough, the dean concludes that faculty require more emotional support from an administrator when they are working with RNs. The students sometimes evaluate their teachers in ways that are not flattering. Moreover, the RN student is far more vocal in the community about the assets and liabilities of the nursing program than is the typical generic student. In short, the whole endeavor of RN education can be most worrisome to a dean, who may soon ask, "Why are we into this?"

The fact is, RN students make use of faculty differently. Faculty members need to teach few technical skills to RN students but are often nonetheless reluctant to trust the students' past learning, technical *or* theoretical. According to McKenna (1980), their attitude often is, "If I didn't teach them, they don't know." It is often difficult for some faculty members to accept the fact that the program is not a remedial one and to value what the student brings. Further, it is difficult to abandon the position of expert, who has mastered the theory and practice of a clinical content area, to join RN students as fellow learners. The adjustment is particularly difficult for those who are accustomed to teaching young students just graduated from high school.

Some faculty members expect the student to undergo some kind of conversion over approximately a two-year period, from a concrete thinker and performer of technical tasks to a self-actualized professional capable of changing the health care system. However, more thoughtful persons count on no such wholesale, startling change. Woolley says, "Although I was completely committed to the program goal of bridging the gap between technical and professional nursing, and although I had taught in both kinds of programs and had a clear idea of what the differences and objectives and curriculum should be, I was in no way prepared for the tremendous tensions that students would experience in making this role change" (1978, p. 103). (The separate project reports describe the behavior changes that did take place among the RN students.) Clearly, further analysis of the expected role change and the behaviors associated with it should be made.

According to MacDonald (1980), the key to success in RN programs is adequate counseling and faculty-student compatibility. Faculty, in fact, are particularly important to a successful RN program. However, administrators need to realize that not every faculty member will be interested in the adult learner; those who are not are better used in other parts of the nursing program.

According to the Liasion Committee for the University of Maryland project, outreach faculty are particularly dedicated people. Despite this—or ironically perhaps even because of it—one problem preventing maximum success in an outreach program is the likelihood that faculty overload will accumulate quite quickly. Teaching time in hours is not the only consideration for faculty members who must travel from the main campus; the commuting time can be the culprit that adds up to overload. In fact, some state-mandated programs are as much as 300 miles from the main campus. And adding to the pressures on outreach faculty members is the fact that the on-campus faculty members sometimes wonder if the outreach staff actually forms a "real" faculty.

Instructors selected to work in satellite programs need a high degree of energy, according to NCP project experience and consultants. Clearly, energy and dedication are needed in the "road-runners" who face the special demands of RN education. Because these people have chosen to work with RN students—often under difficult conditions—we find that their students reciprocate, responding with affection and respect.

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Subsequently the Kellogg Foundation set aside $2.5 million to demonstrate the principles of the recommendations in the nursing programs of the South. Now nearing completion, the demonstration phase of the Nursing Curriculum Project (1976-81) has directly involved 22 institutions and agencies in the 14-state region of the Southern Regional Education Board (SREB). It has touched many more through liaison committees, through the work of the individual demonstration projects, and through periodic reports to the Southern Council on Collegiate Education for Nursing. This monograph, which is one in a series of final reports on the work and findings of the project, was written by Patricia T. Haase.

Staff for this phase of the Nursing Curriculum Project has consisted of: Patricia T. Haase, Director; Mary Howard Smith, Coordinator; Barbara B. Reitt, Editorial Consultant.

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Number 4 in a series of final reports on the Nursing Curriculum Project

Acclimating the Novice Nurse: Whose Responsibility?

The Problem Emerges

As nursing education moved away from its historical roots in hospital-based diploma programs and into the mainstream of higher education, an intractable problem emerged: new graduates of the college-based programs were not as well acclimated to work in the hospital setting as graduates of the diploma programs had been. Employers' expectations and neophytes' abilities all too often did not match. Until the 1960s, the new graduates of diploma programs posed no comparable problem for employers; having already worked in the hospital, they were oriented to its practices and procedures. But as graduates of associate degree (AD) and baccalaureate programs came to represent an ever larger portion of the pool of new nursing talent, and as diploma programs modified their curricula, the dissension between nurses and employers intensified.

According to Lysaught, it was apparent by 1970 that nursing had contributed to the nation's health care "largely in spite, rather than because, of the traditional organizational arrangements and personnel policies of our health care facilities.... Nurses were used essentially as interchangeable parts of the system," (Lysaught, 1981, p. 37). Further, employers expected novices to act "as fully experienced and qualified professionals on the day after their graduation." He pointed out that, in contrast, no one questions the graduate physician's need for training as an intern and resident.

Nurse educators have often pointed to other professions—law and engineering, for example—as models for nursing. Employers of novices in these fields do not expect graduates to begin working without a period for adapting to the world of work. However, nurses' employers argue that costs prohibit an extensive learning period for novices and that such costs should not be assumed by the employer. They maintain that preparatory programs ought to graduate nurses whose work skills are already keyed to the current clinical situation.

During the 1970s, the controversy intensified. In the beginning, complaints were focused on the AD graduate, but as educators moved away from apprentice-type clinical education, the same complaints were heard about other graduates as well. Nursing service directors accused nursing educators of not knowing what to teach. The educators replied that the directors did not know how to use new graduates. The neophyte, caught between, was the immediate victim, but quality health care would ultimately suffer if a solution could not be found.

The Historical Roots of the Problem

Traditionally, teaching a trade requiring manual skills has been done by apprenticing novices to experienced workers. Until the late 1950s, most American nurses were instructed this way. After a six-month pre-clinical period, the student was assigned to a 40-hour workweek, sometimes in addition to class and study time. Students gave hours of nursing service, fulfilling the hospital's needs, in exchange for a nursing education. Student nurses, in short, staffed hospitals.

Most students gained about 4,000 clock hours of clinical experience, often under trying circumstances and without the benefit of consultation or adequate supervision by experienced personnel. Frequently left alone on patient units from 3:00 p.m. until 7:00 a.m., two shifts of students worked eight hours each. During this apprenticeship, students became acclimated to the hospital and its nursing practice. If they chose to work in the same hospital, these graduates were already oriented and needed no additional help to become contributing staff nurses. Understandably, many employers long for the return of the "good old" diploma nurse. However, as a teaching method, this practice left much to be desired except for the sheer quantity of clinical time for student learning and the fact that the students provided most of the hospital's nursing services. These were work-study educational programs, in the poorest sense of the term.

Diploma programs no longer follow this pattern. Beginning in the late 1950s, diploma educators initiated a reform movement that elevated educational standards to approximate those of similar clinical programs in colleges and universities. Clinical clock hours were reduced and instructors accompanied students to the hospital units in pursuit of specific learning objectives. These practices have materially changed the nature of the graduate. The nurse no longer receives on-the-job training and therefore requires a longer orientation program.

Concurrently with these developments in diploma programs, a new concept of clinical teaching was introduced in the AD program, partly in response to nurse educators' desire to prepare a nurse technician in the junior college. Repetitive practice was largely eliminated except where "over-learning" was considered a good teaching strategy. The AD program reduced clinical learning time from 4,000 to 800 clock hours. At the same time, baccalaureate and hospital-based programs also greatly reduced student clinical hours.

A "broad fields" curriculum replaced teaching that had been organized according to medical specialty practice, and students no longer rotated from one medical service to another. Instead, both AD and baccalaureate programs developed integrated curricula in which broad concepts considered central to nursing practice were taught.

Related classroom and clinical instruction might be given on separate days of the same week. For example, Tuesday's clinical situation or patients would be chosen to illustrate Monday's academic material presenting concepts, such as tissue integrity or body image. The practice represented the best in new curricular design, but, from a clinical point of view, could be faulted for decreasing the number of clinical learning hours. According to the critics in nursing service, the "broad fields" approach produced nurses who could (as the expression goes) conceptualize and analyze but not catheterize. After graduation, they needed a transitional period to improve their nursing skills, to become adjusted to longer periods of practice and working different shifts, and to increase their knowledge. Unfortunately, however, marketplace demands prevented the new nurse's enjoyment of a non-traumatic transition into employment.

Although different faculties have tried varying approaches to clinical teaching, no studies have evaluated their effectiveness. Is it best to break down the work role of the staff nurse and teach each part separately, hoping for student insight into the total role during a synthesizing unit near the end of the program? Or should the faculty begin with the total role in simple nursing situations and progress to more complex ones as the program moves ahead semester by semester? Are certain experiences critical to the development of good clinical practice? How many clinical situations should the student encounter before graduation? These and related questions have no clear answers and so deserve the attention of researchers and thoughtful educators.

The Schools Respond: Transitional Courses

Anxious to prepare graduates who could meet the demands of the marketplace, AD faculties moved to make curricular corrections after carefully evaluating nursing service directors' complaints. Schools added courses in critical care and nursing leadership as well as electives in nursing practice. The length of the typical AD program increased; approximately half of the programs are now longer than their original four semesters or six quarters.

One AD faculty created a six-week elective course in nursing practice for second-year students in which students could choose a facility where they wanted to work after graduation, write their own learning objectives, and work on a one-to-one basis with an agency staff nurse, called a facilitator. Students would work from 16 to 32 hours a week to meet the course requirements. The instructor would meet weekly with each student and facilitator and remain on call as a consultant; the facilitator would evaluate the student's potential as a future employee (Martin and McAdory, 1977, p. 503).

The Hospitals Respond: Internships and Orientation Units

By the 1970s, it was obvious that neophytes were coming to hospitals as unfinished workers; hospital in-service staffs were responding by planning and mounting orientation programs of varied purposes, lengths, and intensities. These early efforts are still expanding. Now the pressing question is: Which type of orientation program is best?

In the early 1960s, a few hospitals instituted nursing internships intended to ease the student's transition to staff worker. Since then, the number has grown: the National League for Nursing listed 64 intern programs in March 1981 (NLN, 1981). (This is obviously still a small percentage of the some 7,000 hospitals in the nation.) According to Lewison and Gibbons, the internships were designed to solve three problems: the inability of traditional hospital orientation to prepare neophytes at levels acceptable to supervisors; the nurses' job dissatisfaction, feelings of powerlessness, and the resulting high turnover rates and costs; and the difficulty of recruiting nurses to work in hospitals.

Designed for both AD and baccalaureate graduates, a hospital's program may be as short as two months or as long as a year, and may include a few or more than 40 nursing interns. Some hospitals require all new graduates to enroll, others make enrollment optional; but nearly all require a service commitment to remain at the hospital for a designated time.

All internships have the same central objective: to provide the novice an opportunity to increase clinical skills, knowledge, and self-confidence, smoothing the transition to the role of staff nurse. Hospitals have benefited by becoming more cost-effective and by improving nursing services; nurses have gained by achieving greater satisfaction, competence, and confidence (Lewison and Gibbons, 1980, p.33).

The Richland Memorial Hospital in Columbia, South Carolina, has an intern program that began in May 1979. The program lasts one year and includes both baccalaureate and AD graduates. The objectives are simple: to orient and educate the nurses and to assure their passing the state licensing examination. The rotation plan has five phases: (1) two months on a sponsoring medical-surgical unit; (2) one-month rotations to a variety of medical-surgical units; (3) one month receiving instruction and experience in leadership; (4) four months on a specialty rotation; (5) one month on the unit the intern has selected

for employment after completing the program. A similar rotation system is used by the Medical College of Georgia University Hospitals, where during their first year new staff members are rotated from one clinical service to another, staying for a prescribed period in each medical specialty.

Richland combines several of the typical purposes of nursing internships: (1) compensation—providing further education and experience for nurses who have received inadequate clinical exposure during the basic nursing program; (2) acceleration—providing in-depth experiences for nurses who are interested in specializing in specific clinical areas; and (3) clinical overview—providing orientation to a wide variety of hospital clinical areas. The intern spends several hours each week in classes, workshops, seminars, and conferences, but devotes most of the time in direct patient care, under the direction of a preceptor. The goal is to improve the novice's ability to apply scientific knowledge to clinical nursing practice, which is why discussions of nursing process that emphasize inference and cognitive abilities have been viewed as essential. Each intern also learns organizational and technical skills and becomes better informed about trends and issues in nursing (Lewison and Gibbons, 1980).

Some internship programs differ, giving the new graduate as broad an exposure to the hospital's clinical services as possible. Interns rotate through surgical, medical, obstetric, pediatric, and special care units much as they did in the older diploma programs. The number of units to which students rotate may be as high as 10. There are also internships solely in specialty areas: critical care, obstetrics, pediatrics, psychiatry, and highly specialized medical and surgical units.

Other hospitals have chosen to lengthen their orientation programs, establishing orientation units and individualizing the program for each nurse, thus providing an opportunity for novices to achieve competence as quickly as possible by working under the direction of an instructor (Del Bueno and Quaife, 1976, p. 1629). New graduates are assigned to units that have full-time instructors whose only responsibilities are orienting and educating neophytes. Several nurses can be oriented together on the same unit. The instructor provides the desired clinical experiences and any required formal instruction. Criterion-referenced evaluation tools are sometimes used to measure competence, and the length of the orientation depends on how quickly the nurse meets performance standards.

Rotkovitch suggests that, following a good in-service orientation, the new AD graduate work closely with baccalaureate graduates, clinical specialists having master's degrees, primary assignment nurses, or team leaders "so she can grow in skill in an orderly fashion" and find role models and preceptors. Lacking such opportunities, adds Rotkovitch, the new AD graduate is "confronted with, and frustrated by, expectations she can hardly meet and responsibilities she is not yet ready to undertake" (Rotkovitch, 1976, p. 235).

The Curriculum Project Responds: The Clearwater Project

Having defined competencies for AD graduates, the SREB Nursing Curriculum Project staff was anxious to demonstrate that these nurses could perform at an optimum level if given time to learn the world of work, particularly in a secondary care hospital. Faculty on the Clearwater campus of St. Petersburg Junior College agreed to develop a joint faculty-service plan to demonstrate that belief. Graduates of the Clearwater nursing program were no exception to the general rule that new nursing graduates have difficulty making the transition from student to staff nurse. Nursing leaders in the community, meeting with the Clearwater nursing faculty in the fall of 1976, identified the transitional period as a major point of stress for both graduate and employing agency.

Initial Planning

The Clearwater faculty believed that the modular, individualized learning system, already successfully used at the school, could be extended to provide effective help to graduates and their employing agencies. The basic nursing program at Clearwater, built on a ladder concept (aide-LPN-ADN), was constructed with the assistance of a liaison committee that included nursing service administrators and in-service educators. The committee analyzed nursing tasks, and the findings formed the basis of the modular program of study.

Agencies Participating in Clearwater Project

All Children's Hospital, a specialty hospital with a capacity of 113 beds and employing over 350 personnel

Clearwater Community Hospital, a proprietary medical-surgical acute-care facility of 116 beds and employing 359 personnel

Mease Hospital and Clinic, a 310-bed nonprofit general hospital and clinic employing more than 1,000 personnel

Morton F. Plant Hospital, the largest full-service general hospital in Pinellas County, with 750-bed capacity and over 2,000 personnel

Bruce Manor Nursing Home, a 60-bed skilled-care facility

Clearwater Rehabilitation Center, a 66-bed rehabilitation center with a skilled-care geriatric wing

Highland Pines Nursing Manor, a combined 120-bed skilled care facility and congregate living complex

White House Nursing Home, a 60-bed skilled-care facility

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In designing this new project, the faculty wished to capitalize on the two major assets of the ongoing nursing program: its modular learning system and the open communication between the college and the agencies. The goal was to develop and implement a program of modularized instructional materials that would facilitate the transition of newly graduated AD nurses from student to employee. The employing agencies were to be actively involved in planning, producing, and using the program.

To design the project and assume chief responsibility for it, the college appointed a steering committee composed of the project director, the director of the Division of Health, the chairperson of the Nursing Department, and an educational psychologist. The committee invited eight health-care agencies with a variety of sizes and services to join with the college in forming a consortium and to establish contractual agreement on the responsibilities of consortium members (see box for list of agencies).

It was agreed that, to prepare a curriculum, it would first be necessary to identify both the needs of the new nurse and the requirements of the agency. Core course content that would meet those needs could then be identified. Further, an evaluation tool had to be developed to obtain a data base and evaluate the program results. Modules were then to be written and used in the agencies with the assistance of the facilitators from the hospital staffs. Finally, an evaluation would be conducted.

It was also agreed that the program should be cost-effective, capable of documenting clinical proficiency, and designed to improve job satisfaction and reduce attrition while meeting both client and agency needs. Planners also hoped that an effective curriculum might ease stress for both the graduate and the agency and also influence agency personnel to look more positively at the AD nurse.

Developing the Modules

Two college instructors and two nursing service educators from each agency formed a task force to design the curriculum and modules, meeting weekly to set objectives and overall direction. Each week, the hospital representatives worked two days at the college and a half-day in their agencies preparing materials. Nursing home representatives worked on materials a half-day at the college and one hour in their agencies each week. The consortium's contract specified such college-agency expense sharing.

The task force developed the transitional program after studying the principles of adult education and the needs of graduates and agencies. Each task force member was instructed in learning styles, task analysis, module writing, and evaluation techniques. Applying theory to practice and learning roles by modeling the behavior of others was emphasized.

The core content covered 16 areas of clinical practice: introduction to the agency, safety, infection control, the patient's medical record, admission, nursing process, discharge, transfer of patient within agency, death and postmortem care, patient care quality assurance, pre- and post-operative care, medication, intravenous therapy, patient care management, gerontology, and pediatrics. Modules were constructed so that each agency could use its own policies, procedures, and chart forms. A unit on how to use a module was written for those unfamiliar with individualized modular instruction.

Implementation

Head nurses and nursing service directors in the agencies guided the selection of facilitators—experienced RNs who could serve as role models and who would help the new graduates with the assigned work in the modules. To qualify as a facilitator, a nurse had to show a real desire to undertake the assignment.

In the summer of 1978, a workshop was held to prepare agency personnel for program implementation. Hospital directors of in-service education, head nurses, and the facilitators—206 persons in all—became acquainted with the project, its materials, and evaluation procedures. Thereafter, workshops were held periodically to instruct staff in the use of modules and to orient new facilitators.

As the new graduates were employed by the agencies, each was assigned to a facilitator. It quickly became apparent that the common basis which the modules provided for the learner and facilitator greatly enhanced the orientation. The facilitator not only guided the new nurse through orientation and evaluated her performance but also saw that other unit personnel understood the program. Because new graduates sometimes felt they were just being "sent back" to study more theory, the teachers and facilitators learned to emphasize the "hands-on" aspects of the modules, providing the kind of guidance the novices were hoping to find.

An unexpected by-product of the project was its exposure of deficiencies in the policy and procedure books of many agencies. In some cases, certain policies had never been put in written form; in-house committees found they could use modules as guidelines for revising and improving these materials.

As experience with the program grew, its advantages over previous orientation systems became evident. The performance evaluation included in each module provided agencies with objective observation and documentation of an employee's progress and accomplishments. The modules reduced the time spent by ward clerks, head nurses, and others in orienting new staff. The lessons on intravenous therapy, medication, and patient care were especially popular and seemed to meet particularly urgent needs.

The entire program began to be seen as a means of standardizing nursing practice throughout an agency. Several hospitals used it for all RNs entering their employment, and some introduced the modules for staff self-evaluation. Other agencies noted that the use of the modules greatly facilitated orientation on the evening and night shifts. As word of the program spread, the Clearwater nursing students expressed their intention of applying for jobs in the agencies using it, and nonparticipating hospitals asked about the possibility of acquiring it.

Nursing homes, while supportive of the project and seeing great potential in its principles, faced special problems in participating. Because their staffing was so limited, it was impossible for them to release the RNs more than a half-day a week for the planning phase. Implementation was difficult because the modules were designed for RNs, whereas most of the employees of the

nursing homes were LPNs. In nursing homes, the RN's role is supervisory, and the modules were appropriately not addressed to that function. The nursing home representatives in this project continued an interest in it and urged that later activities include the preparation of additional modules for their particular needs.

Evaluation

The evaluation design followed the classic curriculum development "systems" procedure: analysis of need; formulation of objectives; development and implementation of activities to meet the objectives; evaluation of the activities and their products; and revision, adjustment, or refinement on the basis of findings. Evaluation was built in from the beginning as an integral part of the project.

The major problem addressed was that of quality: Did the new graduates who used the project's model of orientation make the transition to effective staff nurse better than those taking the prior form of orientation? To answer this question, it was necessary to ascertain the knowledge and effectiveness of the nurse at the end of the orientation both (a) from the point of view of the hospital and (b) from the nurse's point of view, and to discover the attitudes of both hospital and nurse toward the quality of the orientation. Thus, the evaluation had two purposes: to test for expected outcomes as defined in the modules and to compare the old and the new orientation systems.

To compare the old with the new, one must measure the same kinds of data in each. It was necessary, therefore, to devise a way to assess the quality of the original orientation process and its product. An instrument was developed and a sample of persons undergoing orientation under the old method was identified before any of the project's modules were written. This was called the "benchmark" sample, the mark against which to evaluate future orientation programs. The research design was simple: comparisons were made on approximately 150 variables between the benchmark group and the group oriented in the project.

The benchmark sample was obtained from January to March 1978 and included over 100 people or 31 cases. (A case combines a supervisor's and the orientee's responses.) Data from the experimental group were obtained over one year, from May 1978 to May 1979, and included 76 cases in this sample. (A case combines the facilitator's and the orientee's responses.) Demographic data indicated that nurses participating in the benchmark sample and those in the experimental group were fairly homogeneous in such characteristics as age, sex, marital status, number of dependents, and previous work experience.

The staff developed three questionnaires for evaluation. One was for the facilitator and a second for the person being oriented. The novice was asked to evaluate the program in terms of (1) the information provided by the agency, and (2) his/her understanding or ability to apply the information provided. The third tool, a follow-up questionnaire for the new employee, was filled out six months after completion of orientation. All three questionnaires elicited demographic data and asked questions in three categories: basic patient care, agency policy and procedure, and patient care management skills. All responses were anonymous, and a system was devised for determining the agency from which the responses came.

A comparison of the benchmark and experimental samples indicates that, with the modular program, there was an improvement in the new graduates' orientation. The facilitators' response to the question "Was the nurse prepared for the position at the end of orientation?" was "yes" in 95.7 percent of the experimental group as compared with only 73.3 percent in the benchmark sample. In their self-evaluation, the novices answered the question "Did you feel prepared for the position you were assigned at the end of the orientation?" with 79.2 percent saying "yes" in the experimental group as compared with 71.1 percent in the control group. The new graduates' lower estimate of their preparedness is consistent with general findings from the use of self-evaluation techniques.

The orientation of the experimental group took longer; participants in the control group spent an average of just under four weeks whereas those in the experimental group spent approximately six and one-half weeks in orientation. However, results indicate that the increase in time produced a better prepared nurse.

Time did not permit a complete analysis of the information obtained, but the following general statements about the evaluation results can be made.

- In basic patient care, no nurse in the experimental group was rated unsatisfactory, indicating an improvement over the benchmark sample.
- Agency policies and procedures also showed great improvement in the experimental group, especially in the manner of presentation and the novices' understanding of and ability to apply policies and procedures in such areas as infection control, patient and/or family referrals, risk management, and patient learning and diversional activities.
- Management skills improved dramatically in the experimental group. Much-needed improvement was seen, for example, in interdepartmental communication, work assignment delegation, and change of shift reports.

An additional comparison of scores of the benchmark and the experimental groups using analysis of variance showed no statistically significant differences in performance. This is a very intriguing finding—Asked to respond in one fashion, a global one, the facilitators enthusiastically favored the products of the new orientation program. Asked to rate the orientees on specific items in a relatively objective manner, they showed no great difference between groups.

This is a cue to look more closely into the evaluation instrument or the training of facilitators. Or, the problem may lie more in the facilitator's values, which all of us build up in relation to making evaluative decisions in our own professions. This is the major problem that has stymied efforts to standardize clinical evaluation in many professions. In this case, the data do not allow us to be sure of the source of this relatively small discrepancy. At any rate, statistically speaking, the orientation method developed in the project seems to have been a resounding success overall, though feedback from the evaluation indicates that it may need modification.

The most exciting finding was that in some of the hospitals the cost of orienting the benchmark group (established before modules were designed and ranging up to $1,600) was higher than the cost of orientation in the experimental program. The savings are particularly

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noteworthy in light of the fact that the experimental program tended to take longer. The use of the transitional modules decreased costs per orientee by as much of $200. Further studies of orientation costs are needed.

Outcomes and Conclusions

Evaluation findings were shared with nursing service representatives in a week-long seminar-workshop. Positive as they are, the findings do not begin to reflect the extent to which the project has stimulated professional adventure for both the college faculty and the nursing service personnel. Benefits have accrued to all three participating constituencies—the college, the agencies, and the new nurses themselves.

The project demonstrated that the AD nurse can indeed function as a competent staff nurse very soon after graduation, fulfilling the expectations of employing agencies.

The project brought the nursing faculty closer to the agencies and made them aware of agency needs. The completed modules supplied faculty with specific information they need to orient students to current practices in the agencies. The project also gave the faculty a whole new perception of the special needs and problems of nursing homes.

Coming together in the project enabled hospitals and nursing homes to identify common problems and to share services and information. Other agency benefits included:

- acquiring a system of documenting both orientation and performance ability;
- learning new methods of course development and instruction;
- establishing a benchmark of knowledge needed for practice;
- identifying the need for continuous updating of procedure books;
- utilizing the modules for additional areas of staff development, including the use of certain modules for orienting non-nursing staff; and
- reducing the costs of orientation.

The college has continued to work with the agencies to revise certain modules and meet requests for new ones. As the project aroused considerable interest among other hospitals in the Clearwater area, the roster of agencies has grown.

Presentations about the project at regional and national meetings have aroused the lively interest of AD programs and hospital nursing departments throughout the 14-state SREB region. The Nursing Department at the college, in response to numerous inquiries, offered a workshop in the summer of 1980 that was attended by 60 persons from 26 health agencies and 12 colleges and universities. Since then, the project materials have been used by several colleges and hospitals around the country.

The project demonstrates that nursing education and nursing service can cooperate, forming a subsystem to achieve common objectives. While developing new relationships, they can maintain their individual integrity and goals. This new method for orienting the novice has great potential for the future of student education and patient services.

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The issue section of this monograph, which is one in a series of final reports on the work and findings of the project, was written by Patricia T. Haase. Authorship of the description of the project was shared by the Nursing Curriculum Project staff and the project participants. Information to prepare the monograph was taken from annual reports, site visits, and evaluation conferences. Project participants were: Anastasia Hartley, Director, Division of Health, Clearwater Campus, St. Petersburg Junior College; Elizabeth Wajdowicz, Chairperson, Nursing Program; Nancy Rue, Project Director; Joy Salatino, Module Writer; and Rosemary Ammons, Educational Consultant.

Staff for this phase of the Nursing Curriculum Project has consisted of: Patricia T. Haase, Director; Mary Howard Smith, Coordinator; Barbara B. Reitt, Editorial Consultant.

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Number 5 in a series of final reports on the Nursing Curriculum Project

Statewide Planning for Nursing

America's health needs are growing and changing with increasing speed, and our resources—human, material, and economic—cannot be handled as if they were limitless. Under such circumstances, planning would seem to be the key to meeting health needs efficiently and economically. If nursing is to serve society as well as it can, a comprehensive system of nursing education should be established. It should be all-embracing and systematic so that it prepares graduates for all different levels and types of nursing practice the health system requires.

We cannot prepare the full range of nurses we need without a system of nursing programs that reflects the structure of nursing knowledge. The Southern Regional Education Board's Nursing Curriculum Project (NCP) has issued recommendations outlining that structure and the educational system it implies (see Box, page 2). To make comprehensive nursing education a reality, the NCP also recommends that nursing leaders and educational policymakers in each state plan a system of nursing education that would allow each component, each individual program in the state, to make its unique contribution and, at the same time, function coherently as a part of the larger whole. Clearly, statewide planning for nursing education is the only means for reaching such a goal.

Planning for nurse education is not a new idea. State studies purporting to match manpower needs with educational opportunities have been issued sporadically since the 1950s. They have focused on the need to alleviate nursing shortages and have had little influence on the quality of nursing practice or the large growth in the number of nursing programs that has occurred. Moreover, none of them dealt with the confusion resulting from the emergence of many kinds and levels of nursing practice.

Interest in statewide planning was renewed in the early Seventies, when the National Commission for Nursing and Nursing Education selected target states and funded statewide master planning committees to look again at the distribution of opportunities in nursing education with respect to manpower needs and the quality of nursing care. Moreover, traditional roles had changed, nursing knowledge increased, and technology was vastly expanded, further complicating the planning task.

According to Lysaught, "the Commission strongly believed in a national pattern for future nursing education and for regional planning and development of undergraduate and graduate programming, but the control of education [was] constitutionally reserved to the states." This fact, coupled with related licensure and practice acts, required an individual plan for each of the 51 jurisdictions involved (Lysaught, 1981, p. 96). From 1970 to 1973, the Commission's staff and regional advisors worked with state nurses' associations, health planning groups, departments of higher education, legislative bodies, and other agencies to establish statewide master planning committees. No one group was designated as being the most effective.

Wishing to build on the foundation laid by the Commission's work, the NCP staff planned its demonstration phase to include projects in statewide planning for nursing education. The staff was particularly eager to place these demonstration projects in agencies that had policymaking responsibilities for educational planning. Given a blueprint of the structure of nursing knowledge and of the kinds and levels of nurses required for practice, statewide planning groups would have at their disposal a regionally agreed-upon pattern that could be adapted to the needs of individual states. The W. K. Kellogg Foundation funded projects based in the Council on Higher Education in Kentucky, the Board of Regents in Georgia, and the State Department of Health in Arkansas to demonstrate the feasibility of adapting the NCP's recommendations to statewide planning for nursing.* These three projects had much in common, and yet each planning operation was adapted to the governmental features and historic experience of the state in which it was located.

Methods of the Projects

The first and most important task of each project director was to establish a communications network among concerned people within a state. Once developed,

*One of the recommendations of the Arkansas Project is to move their efforts from the Department of Health to the State Higher Education Agency (Blagg, Brown, and Thompson, 1981).

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Final Recommendations

1 The practice of nursing at all levels is based on a body of knowledge that has at its center a set of competencies that are universally recognized as necessary to the provision of secondary care. This base of nursing, this set of competencies, should be further defined and developed.

2 The knowledge that is fundamental to each more advanced level of nursing practice is based on sets of competencies, each of which is characteristic of its own level and builds on the base of secondary care. The body of knowledge expands at each more advanced level of nursing practice and includes the different sets of common competencies necessary to the provision of primary, secondary, and tertiary care. The body of knowledge, these sets of competencies, should be further defined and developed.

3 A system of nursing education should be designed and developed to prepare graduates for different levels and types of nursing practice, a system that reflects the structure of nursing knowledge as described in recommendations 1 and 2.

4 The associate degree curriculum should be focused on the preparation of graduates to give secondary care.

5 The baccalaureate curriculum should be focused on the preparation of graduates to give not only secondary care at the beginning level, but also primary care at the beginning level and—at the student's choice—either primary care at an advanced level, secondary care at an advanced level, or tertiary care at a beginning level.

6 The graduate curriculum should be focused on the preparation of leaders to strengthen nursing's contribution to health care; therefore, graduate nursing education should be the first priority of nursing education for at least the next decade. To this end, graduate programs should be prepared to strengthen quality, expand curricular offerings, and increase enrollments.

7 Programs of higher education should incorporate continuing education as part of their regular structure, according it equitable priority in allocation of time, attention, and resources, and assigning to it faculty with academic credentials equal to faculty of other programs.

8 Programs of nursing education at all levels must incorporate flexibility in offerings, requirements, and time-and-place options for study.

9 Programs of nursing education should seek and sustain interinstitutional cooperation in order to strengthen educational services and resources.

10 Curricular structure in nursing should be interdisciplinary. Cooperation and collaboration with other health care disciplines should be sought actively by nurse educators. Where appropriate, joint courses at several levels should be developed and nursing faculty should be given joint appointments in other departments.

these networks could be used to allay fears that the new planning groups would encroach upon ongoing efforts and thus to establish trust among the people representing different interests and health care disciplines. Project directors drove many miles to confer with nursing leaders and educators in their states. They also worked with out-of-state consultants to develop local and regional plans.

Two of the statewide planning groups chose to begin within already functioning Health Service (HSA) geographic areas; Kentucky chose Area Development Districts (Hudleson, 1981). Project directors asked those concerned with the supply of nurses and the quality of nursing practice to offer their views about needed improvements in nursing services. Gradually a picture emerged that centered on particular areas of interest. In each state, a needs assessment conference was held to discuss the identified issues, and interested groups and persons were invited to formally present their views on nursing supply and demand. In this way, health care educators, college administrators, hospital administrators, and nurses in both education and practice were able to contribute to the planning process. In some instances, medical societies, nursing associations, and persons involved in local and state government developed position papers that assisted the project director to prepare an HSA-specific plan for nursing.

For the Georgia project, out-of-state consultants were asked to review the facts, identify problems, and then formulate recommended solutions (Hudson, 1981). They visited hospitals, health care agencies, schools and departments of nursing, and community health programs; they interviewed persons who could assist them in developing the recommendations. The consultants represented both nursing education and practice and were enthusiastically received. These women, leaders of nursing in the Southern region, generously gave their time and expertise to perfect a planning process in a single state. Their suggestions were helpful to educators and practitioners alike.

The other projects did not use outside consultants, but referred planning issues to advisory groups within the state. In these instances, the project staff made the site visits, interviewed responsible persons, and reported their findings to advisory groups and the responsible persons at the agency housing the project.

The advisory groups, composed primarily of nurses, but including others interested in health care education, had important responsibilities. They determined the types and levels of nurses required in the state and the abilities that would be required of them. These advisory groups could view the state's offering in nursing as a coherent whole and make suggestions for needed changes.

Establishing a group of the right size proved to be difficult. It needed to be representative of all facets of nursing, yet not so large that it would have difficulty making decisions.

Individual plans for small geographic areas were developed first and then incorporated into a statewide plan that was reviewed by advisory groups and finally by the governing board housing the project. The planning process made nursing highly visible in each state, changing the way people assessed nursing needs.

Initially, controversy arose as vested interest groups moved to protect their own positions; later, when the final recommendations were determined, influential persons

and organizations who were initially wary of the planning process expressed their support. Nurses began to hope that a better matching of manpower needs to educational opportunities would be done once the problems were more widely understood. They believed that making the problems visible was an achievement in and of itself.

The Issues

None of the planning projects issued prescriptive guidelines for statewide planning, but future statewide planning efforts in nursing education can benefit from a knowledge of issues addressed.

The problems addressed by all three projects are implicit in their recommendations. These are categorized and discussed here as single issues. Although each state had unique concerns and different problems of nursing supply and demand, its solutions closely resembled those of the other states. The issues are discussed in the order of priority that planners assigned them.

1. Assuring that the right numbers and kinds of nurses will be available.

Each state plan seeks ways to assure that a sufficient number of entry-level nurses will be supplied by the educational system each year. To determine this number, answers to the following questions were sought:

- How many nurses are present in the state?
- What are their practice abilities?
- How does the number compare with norms and projected goals?
- How are these nurses distributed geographically?

The state higher education agencies involved with the projects did not collect primary data but, instead, functioned as interpreters and analyzers of data assembled by other groups (licensing bureaus, federal and state governments, and health organizations). Occasionally their interpretations of data enabled policymakers to view nursing manpower needs in a more realistic way.

The projects used different methods for determining these data. Two collected and generated many facts, while the other dealt only with the minimum needed to make effective decisions. In the past, only the number of nurses needed and not their particular skills and abilities were ascertained. The amount of data used in each state reflected its unique needs and resources for compiling such statistics.

Nationally, such data have been collected by the authority of the Nurse Training Act of 1975 (Section 951 of Public Law 94-63), which directs the Secretary of Health and Human Services (Health, Education, and Welfare at the time) to collect specified information concerning the supply and distribution of nurses with respect to their "requirements." These data are then used to determine the adequacy of the nurse supply in relation to the population and the demand for nursing services (U.S. DHEW, 1979, p. 3).

Information is collected on the number and distribution of nurses within the United States and within each state according to educational level, activity status, salary, and specialty preparation. Migration data on nurses entering the United States from other countries are also included. More important, projections are made about the future need for nurses.

The national goal for the optimum number of nurses can be determined in several different ways. The goal can be defined in terms of needs—the number that experts believe appropriate to provide a state of health consonant with existing knowledge. It can also be defined in terms of wants—the quantity of services that would be consumed depending upon prices for goods and services. Finally, it can be based on assumptions about changes in the use of health manpower or the reformulation of nursing roles to match expanded knowledge and abilities (U.S. DHEW, 1979, p. 7).

Pursuant to these definitions, the government contracted outside agencies and businesses to assess national and state requirements for registered nurses (RNs). Vector Research, Inc., assessed the impact on nursing of three probable changes—on both state and national bases—in the health care system: the introduction of national health care insurance, the increased enrollment in health maintenance organizations, and the reformulation of nursing roles. System Dynamics approached the study from a national perspective by analyzing the interaction of factors affecting the requirements and available resources. Under another contract, the Western Interstate Commission for Higher Education (WICHE) developed a model that state task forces could use to determine their own requirements and resources, and yet another pattern was determined to assist smaller groups with the analysis of the distribution of nursing personnel on a sub-state basis. This prototype was developed to provide for a review of county data through a reallocation of RN resources according to the population served (U.S. DHEW, 1979, p. 4).

One model was designed to respond to "what if" questions on potential changes in nursing and the health care delivery system and projected national nursing needs for as many as 20 years.

The second model was developed for state and local planners so that they could project nursing manpower resources and requirements for the next five years. The model was a planning tool that allowed for variations among the states and required judgments and decisions by state and local advisory groups (U.S. DHEW, *Analysis and planning*, 1978, p. 73). In building the state prototype, a panel of experts developed criteria for determining the types and levels of nurses that would be required for future practice needs. The assumptions of the experts were then built into the projection tools prepared by the project.

The NCP staff and the directors of its statewide planning demonstration projects knew from history that the projection of the kinds and levels of nurse workers required, whether on the national or a more local level, is both very difficult and fraught with complex problems. Determining the proper mix of nurses creates the controversy so often associated with statewide planning projects. Should planning be done on the basis of existing needs and demands, or on assumptions about changes in the use of nurses or in their roles? The NCP had determined the kinds and levels of nurses now functioning in the health care system and projected to function in the future, but it had assigned no percentages to the various categories it identified. However, its presentation can properly be said to represent the kinds of nurses now practicing (see Box, page 5).

The first effort at projecting the proper mix of nurses needed for practice was done by the Surgeon General's

consultant group in 1963. It recommended only *percentages for levels* of nursing practice: 50 percent of nurses from diploma and associate degree programs, 40 percent from baccalaureate programs, and 10 percent prepared in master's and doctoral programs. At the beginning of the NCP in 1972, some eight to nine years later, these projections were far from attainable through the existing system of education. At that time, among the nation's registered nurses, 81 percent graduated from diploma and associate degree programs, 15 percent from baccalaureate programs, and 4 percent were prepared at the master's and doctoral level.

The WICHE contract in the late 1970s had projected the nation's need for nurses by 1982. According to the criteria developed by the WICHE panel of experts, the 1982 national distribution of RNs by educational level would be: associate degree and diploma graduates—35.7 to 33.7 percent; baccalaureate graduates—47.6 percent to 47.4 percent; and master's and doctoral graduates—16.7 percent to 18.9 percent. This goal will not be reached by 1982.

Planning groups projecting numbers of needed nurses without considering their skills and knowledge have been able to project surpluses of nurses by 1990 (Galambos, 1979). These projections were determined, however, before nursing shortages were reported.

Fortunately, the NCP's three statewide planning projects were able to move beyond the point of simply projecting the levels of nursing practice required, calling more precisely for the preparation of types of nurses to serve particular health care needs. In fact, one of the accomplishments of these projects has been the recognition by the planners of the necessity of viewing manpower requirements simultaneously with health-illness needs of the state—achieving this for the first time.

2. Planning for interface with the needs for health-illness care in the state.

All of the statewide plans recognized that planning for education should harmonize with the needs and demands of the health care delivery system. This required the collection of a second set of data concerning health-illness needs and present deficits of nurses in health service agencies. Planners analyzed the various employment settings in which nurses worked to better determine an agency's needs and demands for nurses, and they considered morbidity and mortality statistics. Was there, for example, a high infant mortality rate in a certain geographical area, a high rate of morbidity for certain diseases, a lack of access to health care for certain populations?

In addition, data were collected about the provision of health care in the state:

- How many hospitals and beds existed for tertiary care, secondary care, or extended care for the aged and permanently handicapped?
- What were the staffing patterns? What was the turnover rate?
- How did these figures compare with state goals or national and regional norms?
- How many community health agencies were there?
- What were the differences in services in private and governmental agencies?
- How extensive was the rural health program in which nurses were active participants?
- What was the state contribution for Medicaid?
- What were the special programs supported by local and state governments or private agencies?

These facts combined with the manpower statistics created a statewide picture that could be compared with various models—the NCP recommendations, WICHE's planning projections, or others devised by state task forces or advisory groups. Several Southern states (Alabama, Arkansas, Kentucky, Mississippi) have used the WICHE pattern for projecting nursing practice needs, finding it useful for two reasons: first, because a set of numbers could be generated and plugged into an already prepared computer program in a relatively short period of time; and second, because the sets of data thereby derived were based upon the state's advisory group's assumptions about health-illness needs and the levels and types of nurses needed to provide them. The advisory group would work from pre-formated worksheets to project the actual number of types and levels of nurses required for their state according to the assumptions of the WICHE model.

Usable data were also available from such national and state care organizations as the American Nurses' Association (ANA) and American Hospital Association (AHA), from licensing boards, and from various departments of the federal government. State planning groups collaborated with state agencies which were primary collectors of data, asking them to collect data the planners considered relevant to statewide planning for nursing.

Planners in all three projects believed that they got better results if the projections were first done for HSAs, cities, or counties, and then coalesced for the statewide plan. One reason was the difficulty in addressing both rural and urban needs in one document or set of assumptions. But whatever way the state decided to collect data, the planners arrived at a set of projections that answered these questions:

- How many educators, administrators, and researchers are required for safe practice?
- How many workers are needed in tertiary care?
- How many nurses should there be for primary care to work in clinics, rural practice, and community health agencies?
- How many providers are needed for secondary care in hospitals?

Each of the three projects specified in their recommendations the various kinds and levels of nurse workers in short supply in their states and called for plans that would meet those needs with forthcoming new graduates. The educational backgrounds and abilities of nurses in the current manpower pool show strong vocational leanings in all the states. This finding was generally in line with estimates Lysaught reached in his evaluative work for the National Commission on Nursing and Nursing Education. There are surpluses of LPNs and ADNs, but large deficits of nurses prepared at the baccalaureate and graduate levels of practice (Lysaught, 1981).

Planners recommended that in primary care, nursing education provide for sufficient numbers of nurses in both urban community programs and rural health plans and facilities (practitioners and midwives). Nurse involvement was thought to be particularly important in maintaining the quality of care for a number of specific groups: for the

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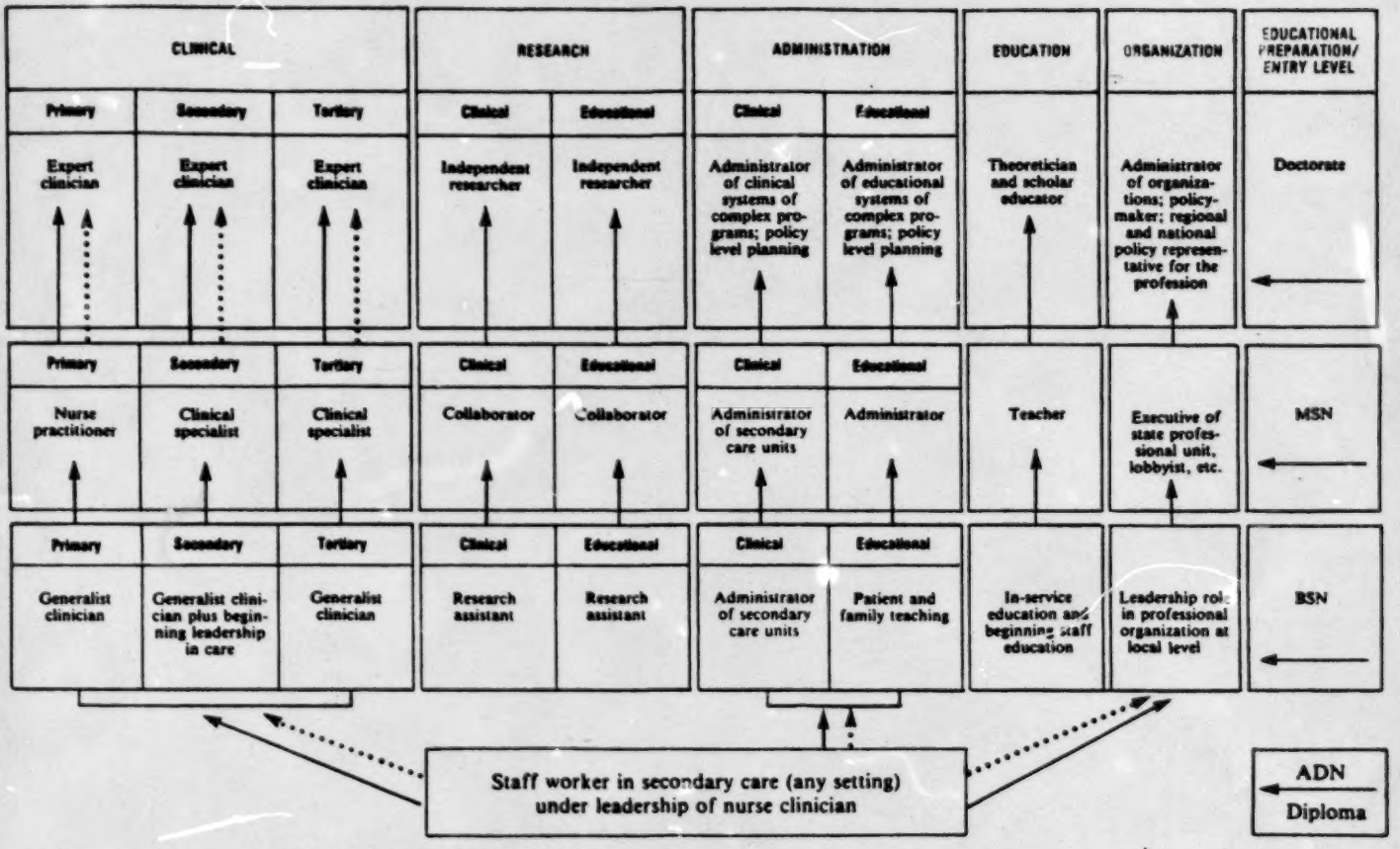
Categories of Nursing Practice



elderly, particularly in ambulatory and home health services; for children in child care centers and schools; for adults in occupational health facilities; and for the chronically diseased and the disabled.

Although state higher education agencies have no regulatory concern over hospitals, they nonetheless expressed their wish to see hospitals pay higher salaries to nurses who excel in the direct care of patients. All agreed that it was inappropriate that nurses farthest from the bedside were receiving the highest salaries. Statewide plans also advocated the development of clinical as well as managerial leadership tracks for nurses employed in hospitals. Their recommendations pointed to the advantages of preceptorships, internships, joint appointments, and other means of enhancing excellence in the clinical component of the teaching program.

Currently, program approval involves both state higher education agencies and state boards of nursing; sanctions from both governmental bodies are necessary before new programs can be opened or older programs merged. In contrast, closure of state-supported, college-based nursing programs can be accomplished by either board without the prior approval of the other.

The three statewide planning projects recommended the continuation of the effort after the project ended. The suggestions for responsibilities of these new planning bodies varied; they included:

- Making ongoing decisions about the desirable balance of graduates in any one state;
- Evaluating feasibility studies before approval for new programs is given;
- Identifying needs for and putting into place RN educational mobility programs;
- Closing all entry-level programs except for associate degree and baccalaureate ones;
- Closing and merging programs that have low production of graduates, high state board failure rates, low enrollments, and that are a duplication of effort in any geographical area.

It was suggested that moratoriums on new programs remain in force until the proper mix of programs can be put into place.

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3. Issuing statements about the role and function of nurses.

Another problem for statewide planners was the continuing confusion in the health field about roles and functions of the various types and levels of nurses. Much work has been done both in the region and at the national level to solve the general confusion by describing curricular outcomes in terms of the competencies of the graduate of each kind of nursing program. The focus is usually on ADN and BSN graduates, but in the NCP, attention was also directed to the description of outcomes for the master's graduate.

It has been the experience of the staff that no statewide planning group is likely to accept the work of others, despite its availability, in defining nursing roles and functions. Each state develops its own statement. Each state project, then, established committees and task forces to identify competencies for various types and levels of nursing practice, to identify the accountability and scope of practice for each, and, in some instances, to determine new titles for workers and a legal definition for the scope of their responsibilities.

Some of the controversy may be the consequence of the time lag between establishment of realistic goals, their endorsement by individual nurses' organizations, and their implementation in a state. This is not, however, to overlook the fact of genuine confusion about the employment of various levels of nurses in hospitals. The reasons for the disarray are complex. Educators can be blamed for not developing different levels of educational programs in concert with each other. Montag has said that there might be less role ambiguity and debate today if programs and requirements for technical and professional practice had been spelled out from the beginning. The American Hospital Association's (AHA) Commission on Nursing points out that this simpler curricular approach would have resulted in two levels of nurses and two kinds of programs. Such a simplified system of education would then have been carried through to the practice setting with different job descriptions according to educational preparation, and different salary structures according to the amount of responsibility for each (National Commission on Nursing, 1981, p. 47). But hospital and nursing service administrators must also assume some of the responsibility for this role confusion. They refused to adapt their staffing patterns to the kinds of graduates they employ and to provide an adequate novice period for new graduates just learning the world of work.

Several Southern states have been successful in composing sets of competencies for various levels and types of nurses. Not only were the three statewide planning projects successful in their attempts, but nurses in South Carolina, Mississippi, Florida, and Texas also recently developed their own statements about the differences in graduates from various preparatory programs.

Ideally, the formal organization of these competencies will reveal logical patterns for educational mobility programs to follow. Such programs have been highly touted by the statewide planning groups. The NCP's statement about nursing competencies was built on a theoretical framework that promoted just this end.

4. Assuring access to nurse education programs.

Nurses' ready access to educational mobility programs has been warmly endorsed by statewide planning groups. Specifically, they have recommended the provision of appropriate credit in the next highest program, competency-based testing centers, interinstitutional collaboration for the purposes of providing educational mobility and outreach programs.

Planners have targeted such programs particularly for geographical areas of greatest need. Not all these methods can be effective for any one location. Outreach programs especially should be preceded by well-designed feasibility studies with minute attention to costs and probable enrollments. The per-student costs in rural outreach programs may be quite high and faculty overload is very likely.

Experience shows that master's programs for outreach students influence the quality of teaching in nursing schools and of nursing service in hospitals. These programs are generally well attended and usually considered to be worth their costs. Baccalaureate outreach programs, on the other hand, are best received in urban areas, where they prove to be cost-effective.

RN educational mobility programs are growing rapidly. They are usually designed to be directly articulated with other programs on the same campus or as part of a generic progam in nursing. (See the *Pathways to Practice* monograph series on RN education.)

5. Fostering collaboration between nursing practice and nursing education.

Each of the planning task forces felt that the division between the goals of nursing education and the realities of nursing practice blocked the further advancement of nursing in their state. Each project, therefore, suggested the formation of joint education/practice committees to make recommendations about role, function, and competencies of various types and levels of nurses. The Georgia plan suggested that joint committees might help resolve problems in such trouble spots as staffing patterns, working conditions, and salaries. Recommendations also asked for joint planning by colleges and health agencies for ways to assist the nurse novice during the difficult transition from student to staff nurse (see the *Pathways to Practice* report, "Acclimating the Nursing Novice: Whose Responsibility?").

Planners encouraged graduate programs to assist faculty in maintaining clinical skills. The clinical expertise of faculty has long been a major concern in hospitals and other health care agencies. Advisory groups and project staff members discussed some new ways for faculty members to participate in clinical practice. Various types of faculty arrangements were explored for their usefulness in establishing a better balance of faculty responsibilities in education, practice, and research. The unification model—described by Christman and Ford—was thought to be ideal because it emphasized the clinical expertise of faculty (see Lysaught, 1981). Joint appointments were looked upon with favor, especially those that involve joint reimbursement of faculty members. The advisory groups also favored faculty members arranging their own clinical practice positions.

6. Giving highest priority to the preparation of nurse leaders.

All of the planning projects agreed that opportunities to prepare nurse leaders should be expanded. In spite of increased numbers, nurses prepared at the graduate level still constitute only four percent of the work force. Recommendations included increasing the accessibility of graduate programs, expanding offerings in existing ones, and generally giving priority to graduate programs in nursing at the master's level. Specifically, plans called for increasing emphasis on the preparation of nurse administrators and on gerontological and rural health nursing. All are taught at the master's level and were found deficient of their needed component of nurses.

The graduation of nurse leaders has long been a concern of the highest priority among nurses. In nursing education, the needs are sometimes acute. Many faculty positions are filled by nurse educators who do not have the terminal degree required of other faculty on the campus. About 50 percent of faculty in ADN programs do not hold the master's degree.

The situation is even more acute in nursing service administration. Seventy-three percent of nursing service administrators hold less than the master's degree. Yet the AHA's Commission on Nursing generally agreed that preparation at the master's level was "essential" for effective participation in "executive management" (National Commission on Nursing, 1981, p. 18).

Davis found that the quality and quantity of patient care improved with increasing education of the nurse and was the highest for clinical specialists with master's degrees (National Commission on Nursing, 1981, p. 46). Nurses in hospitals are not the only ones lacking clinical leadership; there are similar deficits in primary care. Community and public health agencies are functioning without their proper complement of master's prepared nurses. Another state planner's recommendation was that master's programs to prepare various kinds of nurse practitioners be fostered and ad hoc certificate (practitioner) programs be discontinued in the state plans.

Doctoral programs in nursing were much discussed but specific recommendations were delayed until a critical mass of applicants could be recruited or fully prepared faculty could be employed. Educational mobility programs at the master's level had a higher priority in planning.

7. Vigorously promoting nursing research and implementing the findings.

The lack of qualified nurse researchers was of concern because of the paucity of good studies about practical problems. There has yet to be a definite study on the differences between nurses prepared for practice in different programs. Nursing research has too few studies of effective staffing patterns in hospitals. Studies are not usually directed toward relieving patient discomfort and improving recovery rates.

Recommendations concerning nursing research in the statewide projects varied, from a call for a formal research plan to the development of a statewide research center. Recommendations also supported the establishment of research positions in both practice and education and a greater emphasis on research relating directly to practice concerns.

8. Assuring the continuing competence of nurses.

Most statewide plans call for a highly structured continuing education program to reach large numbers of nurses in the state; judged necessary whether the state has a mandatory continuing education law or not. The Arkansas formulations called for release time for hospital nursing staff to attend pertinent educational conferences and courses, or, on the other hand, opportunity for self-directed growth according to a plan to be initiated between a single nurse and her/his employer.

9. Funding of nurse education programs that is fair and equitable.

Investigations into costs of various nursing education programs revealed grave discrepancies in funding. In one state a vocational program training nurse technicians was costing more than the formal graduate program in its entirety. Costs per student at different state-supported institutions ranged from a meager provision to a rich one. Rational explanations for these discrepancies were hard to find. The statewide plans recommend changes in funding formulas, financial aid programs for students, and cost-effectiveness studies for schools and colleges.

10. Continuing statewide planning after the completion of the initial project.

Each of these projects, like others around the nation, have recommended that some means be found to continue the planning process for nurse education. The Georgia plan asks for an advisory committee to the Board of Regents, and the Kentucky plan calls for a permanent employee of the Council on Higher Education who would be responsible for planning for nursing. Nursing may be a small group numerically, but the community's demand for different kinds of nursing education programs to meet the health-illness needs of the people make planning absolutely essential. No single level or type of nursing program can be expected to meet these needs.

Functions that could be assigned to permanent planning officials or groups include:

- Monitoring the implementation of the statewide plan devised in the initial project;
- Adjusting the plan as need arises;
- Continuing to collect and update statistical data; and
- Identifying problems that will require planning in the future.

The planning groups hoped that future planners would help improve relationships between nursing service and education, develop a quality assurance tool for program approval and evaluation, and develop a statewide plan with specific recommendations about what the contribution of each institution should be.

11. Miscellaneous recommendations.

Miscellaneous recommendations referred to nursing assistants and their role and function, educational program improvement, recruitment of nurses, emphasis on the education of minority groups in nursing, and strategies for staff retention. Additional recommendations called for changes in fiscal policy to permit financial support to those nurses working in primary care or reimbursement mechanisms that would allow them to practice.

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According to Lysaught, despite the general satisfaction with the continuing growth and development of statewide master planning committees, one out of every four states still has not moved aggressively toward the planning of an educational system for nursing that can solve the accumulated problems of the last 60 years. Our agenda can never be completed until every state has developed guidelines and deadlines for the reconstruction of its educational patterns for nursing preparation. Much has been done; more remains to be accomplished (Lysaught, 1981, pp. 96-97).

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Synopsis of SREB's Nursing Curriculum Project 1972-1981

The Southern Regional Education Board's Nursing Curriculum Project (NCP) was funded in 1972 by the W. K. Kellogg Foundation of Battle Creek, Michigan, to clarify varying nursing program goals and determine their relationship to each other. The project's specific aims were to develop a set of assumptions about health care needs, propose kinds of nursing personnel to provide the full range of services implied, and propose a blueprint for nursing education to prepare these types of nurses within the education system.

The work of this first phase of the project (1972-76) was done by a 36-member seminar which met six times over a three-year period to determine the parameters of nursing knowledge and practice, roles for various categories of providers, and directions for future development in programs of nursing education. Recommendations to achieve a congruent system of nursing education were completed in 1975.

Subsequently the Kellogg Foundation set aside $2.5 million to demonstrate the principles of the recommendations in the nursing programs of the South. Now nearing completion, the demonstration phase of the Nursing Curriculum Project (1976-1981) has directly involved 22 institutions and agencies in the 14-state region of the Southern Regional Education Board (SREB). It has touched many more through liaison committees, through the work of the individual demonstration projects, and through periodic reports to the Southern Council on Collegiate Education for Nursing.

This monograph, which is one in a series of final reports on the work and findings of the project, was written by Patricia T. Haase. Information to prepare the monograph was taken from annual reports, site visits, and evaluation conferences. Project directors were: Kathye Blagg (Arkansas Statewide Planning and Development Project), Richard A. Hudson (Georgia Statewide Assessment of Nursing Education Project), Irene M. Hudleson (Kentucky Statewide System of Nursing Education Development Project).

Staff for this phase of the Nursing Curriculum Project has consisted of: Patricia T. Haase, Director; Mary Howard Smith, Coordinator; Barbara B. Reitt, Editorial Consultant; and Audrey F. Spector, SREB Nursing Programs Director.

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